Nebraska
Guidelines for Mass Administration of Vaccines and Prophylactic Medications

State of Nebraska Office of Homeland Security
And
Nebraska Health and Human Services System

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In Collaboration with the Nebraska Emergency Management Agency

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Draft Plan for the Focused Administration of Vaccines and Prophylactic Medications

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Mass Clinic Manual Format

- Concept: The same general process is used for any mass administration of vaccines and/or medications.
- The first part of the manual addresses general aspects and guidelines for mass provision (i.e. collaboration, inventories of resources, clinic flow, job responsibilities).
- Annexes are attached that provide additional direction about specific events (i.e. smallpox, anthrax, etc.)
- The guidelines and plans must be tailored to meet the individual needs of each area, taking into consideration a number of factors unique to that region (i.e. population demographics, physical and personnel resources, threat/risk of exposure).

Operational Concepts for Clinics

- The Directors of the local health departments as recognized by LB692, plus Dakota, Scotts Bluff and the Sandhills Multi-county Health Departments, are responsible for planning and clinic operations in their jurisdictions. If the health department does not yet have a director or if the director needs assistance, HHSS will provide technical assistance as requested, to ensure that planning and implementation occur.
- Geographical/political subdivisions for smallpox clinics will be consistent with the geographical areas of the local health departments as recognized by LB692, and are referred to in the plan as “Designated Clinic Planning Regions”.
- The Strategic National Stockpile (SNS) and clinic plans will be consistent regarding drop sites, storage facilities, etc.
- In developing the region’s response plan, the local health director will work with the local emergency planning officials (and the local emergency operations plans) in all counties in that designated clinic planning region.
- Planning and clinic operations will require a collaborative effort and use of multiple local resources (i.e. hospitals, schools, Emergency Medical Services, industries, vendors, volunteer organizations, service agencies, medical providers).
- Each region will need to identify and maintain an inventory of local resources to include, but not be limited to:
  - Secure storage areas for vaccine and/or pharmaceutical supplies
  - Immunization providers
  - Other potential ancillary personnel for clinic operations and responsibilities
  - Potential clinic sites and contacts for those sites
  - Location and number of ‘shut-ins’
  - Vendors and industries
  - Translators
  - Service agencies
  - Licensed medical providers, law enforcement, National Guard/Military, etc.
- Experienced personnel from local public immunization clinics will be identified in each region to provide coordination and guidance during mass clinics.
- The State will use established EMS training facilities/infrastructure and regions to provide statewide training regarding clinic operations and logisitics. This will provide multiple training sites and times, thereby providing the opportunity for agencies to stagger attendance at trainings.
- UNMC/Creighton will focus on medical provider education on smallpox disease, care, isolation, vaccine contraindications.
- The NHHSS website will be used to disseminate information to providers, state and local public health personnel and the general public. Topics will include, but not be

limited to disease specific information, cases and locations, transmission, prevention/protection, ongoing control efforts, clinic sites, locations, times, printable consent forms, contraindications and side effects, etc.

- HHSS staff will 'trouble shoot'/provide technical assistance across the state to clinics. NE HHSS will train local health department staff and infection control nurses at hospitals to conduct disease investigations, using the CDC case investigation forms and guidelines.

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SMALLPOX RESPONSE PLANNING CONTACTS AND WEB SITES

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Web Site regarding Bioterrorism and Smallpox

- Nebraska Health and Human Services System: www.hhs.state.ne.us
- Public Health Association of Nebraska: www.PublicHealthNe.org
- Centers for Disease Control and Prevention: www.cdc.gov

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Definition of Terms and Acronyms

NOTE: In this document, local health departments are those county and multi-county health departments recognized in LB692, plus Scotts Bluff County, Dakota County and Sandhills Multi-county Health District

ACIP: The Advisory Committee on Immunization Practices; the nationally recognized group of public health and private medical experts who advise the U.S. Department of Health and Human Services on immunization practices

BT = Bioterrorism

CDC = Centers for Disease Control and Prevention

DIS = Disease Investigation Specialist

EMS = Emergency Medical Service

IND = Investigational New Drug

LEOP= Local Emergency Operations Plan

MOU = Memorandum of Understanding

NE HHSS = Nebraska Health and Human Services System

NEMA = Nebraska Emergency Management Agency

SEOP = Nebraska State Emergency Operations Plan

SPS = Strategic National Stockpile

VC = Vaccination Clinic

VIG = Vaccine Immune Globulin

VIS = Vaccine Information Statement

I. INTRODUCTION

Advance planning for a coordinated public health response to a bioterrorism (BT) event or significant epidemic (i.e. pandemic influenza) is essential. It is highly likely that the public health response will include mass administration of vaccines or prophylactic medications to large numbers of people in a very short period of time. Warning periods are expected to be very short and tremendous personnel and material resources will be required during such a response.

It is assumed the major BT agents include anthrax, plague, smallpox, tularemia, and botulism. Antibiotics will be used in a response to events involving anthrax, tularemia, or plague. Antitoxin for botulism is available from the Centers for Disease Control and Prevention (CDC) in limited supply. Vaccine will be used in response to a smallpox event and pandemic influenza, and possibly for an anthrax event depending on availability. Supplies of vaccine and treatment drugs may be limited; therefore, it is possible that priority populations will have to be identified and administration take place accordingly.

This document addresses advance planning and managing an actual clinic response, should an event occur which requires the NE Health and Human Services System (NE HHSS) to respond with a mass immunization or prophylactic medication clinic. The manual starts with general guidelines that apply to all mass clinics; annexes are attached that address specific disease agents (i.e. smallpox), related vaccines and treatment medications. The document is organized as much as possible into lists and forms. Each of the state's designated clinic planning regions can adapt the materials easily to plan and coordinate a local response. In the event that the Governor declares an Official State of Emergency, this document should be used in conjunction with the Nebraska State Emergency Operations Plan (SEOP).

NOTE: Every effort will be made to up-date this document with the most recent Federal requirements, recommendations and guidelines; regardless, NE HHSS will follow the latest requirements issued by the Federal Government and Centers for Disease Control and Prevention (CDC) and use the latest CDC recommendations and guidelines related to the diagnosis and control of agents of bioterrorism, vaccine and medication handling and administration, and the operation of mass clinics.

II. OPERATIONS PHILOSOPHY

State, regional and local public health officials, local emergency management directors and communities must work in a coordinated, organized manner when dealing with the serious issues presented by a bioterrorism attack or other significant epidemic. One critical response component is the ability to provide vaccination or treatment to large numbers of people in very short periods of time. This is most often done through mass public clinics. NE HHSS will provide direction and coordination at the state level for mass clinic planning and operations. Local health departments will oversee planning and implementation of mass clinics in their counties.

The resources available to operate mass clinics vary considerably across the state. It is the responsibility of NE HHSS, local health departments, Nebraska Emergency Management Agency (NEMA) and other partners to make the best possible use of existing state and local public, private and volunteer resources. State and local planning will include the identification of resources, determining the areas' service delivery capacities, identifying gaps in service delivery, and securing and providing the additional resources necessary to address the areas' threat.

The Nebraska Emergency Management Act grants the Governor authority to provide state-level support to local governments in times of extreme emergency or disaster. Each local government is under the jurisdiction of and served by NEMA and is required to participate in an emergency management organization that has either a full-time director or full-time deputy director. The Nebraska State Emergency Operations Plan describes how State Government responds to occurrences of disasters and emergencies throughout the State. **The planning for mass clinics requires special emphasis on certain functions that are not specifically addressed in the Nebraska State Emergency Operations Plan (NE SEOP).** The Nebraska Guidelines for Mass Administration of Vaccines and Prophylactic Medications is considered a partner document to the NE SEOP; however, an official emergency does not have to be declared for any or all of the Guidelines to be implemented by NE HHSS.

III. SUMMARY OF RESPONSIBILITIES

A. NE HHSS

1. Preparation

   In preparation, NE HHSS will:

   a. Coordinate statewide planning with appropriate state agencies [i.e. NE Public Health Laboratory (NPHL), State Patrol, Emergency Management Services (EMS), NEMA)] and clinic planning regions/local health departments;
   b. Develop and distribute plans that the state's designated clinic planning regions can use as templates for focused prophylaxis and/or vaccination delivery. Clinic planning regions will be comprised of the same geographic areas as the local health departments;
   c. Continually update the plan to reflect current resources and threats and disseminate the updates to the regions and other response partners;
   d. Identify and prioritize high-risk populations to receive vaccine and/or prophylactic medications;
   e. In collaboration with state and local public and private partners, develop and oversee plans for pre-vaccinate priority populations, as approriate;
   f. Develop and implement a statewide training plan and supporting materials (e.g. manuals, brochures, on-line and computer based training);
   g. Serve as the primary point of contact with the CDC in ordering, receiving and distributing vaccine, prophylactic medication, supplies and/or the National Pharmaceutical Stockpile across the State;
   h. Work with designated clinic planning regions to identify regional and local supply coordinators, and state and/or regional inventories of clinic supplies;
   i. Outline a plan for timely and equitable distribution of supplies, vaccines and medications to clinic locations;

j. Assist the CDC and clinic planning regions in receiving and disseminating national program updates, and communicating and disseminating accurate and timely information to the public concerning vaccine and/or prophylactic medication distribution;
k. Work collaboratively with public and private partners to educate the general population pre-event about potential bioterrorism and epidemic events and response activities that will be implemented, including the communication methods (i.e. websites, media) that will be used to update the public on the situation, clinic sites, preventative actions, etc.
l. Develop and establish Memorandums of Understanding (MOUs) with identified clinic sites, storage facilities, suppliers, agencies and other partners, as appropriate.
m. Develop and distribute to the clinic planning regions/local health departments, protocol and directions regarding waste management and decontamination guidelines (Decontamination Guidelines, CDC Annex F). Protocol will be consistent with Federal and State requirements and guidelines.

2. Response

In response to a BT event, NE HHSS will:

a. Ensure timely, appropriate and equitable distribution of vaccine, prophylactic medication and supplies (medical supplies, forms, educational materials, etc.) throughout the affected areas;
b. Provide on-going consultation and assistance, as needed, to the regions' clinics;
c. Conduct clinic site visits;
d. Coordinate overall evaluation of vaccination and prophylaxis efforts statewide;
e. Maintain, consolidate and analyze data and provide feedback to clinic planning regions concerning the effectiveness of clinic activities, control measures, follow-up activities, proportion of targeted populations vaccinated and/or treated, and vaccine and/or prophylactic medication inventories.
f. Work collaboratively with federal, state and local partners to provide ongoing information to the public on the situation and response activities taking place.

B. Designated Clinic Planning Regions

Designated clinic planning regions cover the same geographical area as the local health departments.

1. Preparation

In preparation, the designated clinic planning regions will:

a. Review and use this document to prepare for and provide mass clinic services;
b. Be familiar with the contents of the document, including the disease/incidence appendices;
c. Identify and delineate a clear command structure for the region, with defined roles and responsibilities, including a designated contact/liaison with NE HHSS staff;
d. Assess and define partnerships with the region's local organizations which may be involved in providing clinic services (i.e. EMS, private medical providers, pharmacists, dentists, veterinarians, community action agencies and other community based organizations, community medical clinics, nursing homes, hospitals, schools, extension agencies, universities and

colleges, student health centers, businesses, media, retired health care professionals, law enforcement agencies, Veterans Association and other volunteer organizations);

e. Summarize the region's estimate vaccine and prophylactic medication needs. (Pages ___)
f. Identify clinic locations and secure storage sites for vaccine, medication and clinic supplies;
g. Ensure that clinic supplies (other than vaccine and/or prophylactic medication) are readily available, either locally or from the State;
h. Obtain medical authorization and standing orders for administration of vaccine and/or prophylactic medication at clinics.
i. Collaborate with NE HHSS as outlined previously.

2. Response

In response to a BT event, the designated clinic planning regions will:

a. Activate the plan to operate clinics, ensuring timely and equitable distribution of vaccine and/or prophylactic medication within the region, according to the prioritized populations identified;
b. Request necessary materials from NE HHSS and identified suppliers;
c. Coordinate communication activities with NE HHSS to ensure the messages are consistent, timely and appropriate;
d. Working with NE HHSS Office of Communications, distribute informational memorandums to physicians, hospitals, long-term care facilities, schools, universities, and major employers when necessary;
e. Collect and summarize clinic-related data (i.e. patient demographics; vaccine administration; vaccine/medication and supply inventory) and forward to NE HHSS;
f. Provide feedback and evaluation to NE HHSS following an event.

Other items to include (determine where in guidelines to put this information – whether in the clinic guidelines, the larger BT response plan, or both)

- *Solidify communications and responsibilities among federal/state/local officials and emergency agencies, press, safety, health, others*
- *Consider locating clinic coordination staff with emergency operations staff for better coordination and communication*
- *Outline plan and responsibilities for ongoing monitoring of clinic activities and utilization in order to provide regular updates to public regarding "wait time", etc.*
- *Conduct regular briefings with collaborating partners (federal, state and local) in order to evaluate activities, anticipate future issues, etc.*

IV. ADVANCE PLANNING

A. Scope of Response

Established protocols ensure a coordinated response during an event. Contact lists are being developed which identify the technical staff responsible for surveillance and response measures. Data from epidemiologic investigations done by designated public health officials, in coordination with the CDC, will delineate the size and scope

of the event. The amount of vaccine and/or prophylactic medication available and the possibility that additional new and epidemiologically related cases will be identified in subsequent days will influence the degree and scope of the response necessary to prevent and protect.

The following lists of services, businesses and personnel will be generated by the designated clinic planning regions. The information will be used by the regions to formulate each region's individualized response plan. The lists will be kept within each designated clinic planning region and on file at the State.

- Public Health Strike Force
- Persons vaccinated pre-event ("first line responders")
- High risk populations and prioritization
- Clinic region's "administration" teams, including the regional clinic administration supervisor, trained nurses and others who are credentialed to administer pharmaceuticals
- Other clinic personnel and volunteers
- Clinic location contacts
- Clinic support services (emergency services, law enforcement, mental health, sanitation, etc)
- Regional hospitals
- Clinical laboratories
- Pharmacies
- Translators/language lines

In addition, regions may want to generate and maintain information regarding:

- Area industries, businesses and capabilities (i.e. refrigerated storage facilities; trucking firms; schools; public auditoriums; media)

B. Estimating Vaccination and Prophylactic Medication Needs

1. Pre-Event

For any event and level of response, there will be a group of individuals who should be prioritized to receive vaccine and/or prophylactic medication. The HHSS Chief Medical Officer used and will continue to use an Ad Hoc Vaccine Advisory Subcommittee of the NE Bioterrorism Advisory Committee to advise NE HHSS on the administration of vaccines and/or prophylactic medications to certain pre-designated individuals and identified target populations. The structure of the subcommittee advisory group will be similar to a hospital ethics board. The members will acknowledge that their decisions center around potentially conflicting values and that a key question to address will be, "What are we intending to prevent?" (i.e. death, serious illness, overall burden of illness, economic and productivity loss). The advisory group will be broadly representative and will include, at a minimum, an epidemiologist, state and local public health officials, an ethicist, a representative of the NE Legislature Health and Human Services Committee, a representative of the medical community and a citizen.

The subcommittee will be asked to identify a Public Health Strike Force that will be the first to receive vaccination and/or medication, preferably prior to an event

depending on availability and medical appropriateness. The subcommittee will also identify and prioritize other target groups. The Subcommittee's recommendations will be based on:

- Federal guidelines and published research;
- The availability of vaccine and/or prophylactic medications;
- Specific job responsibilities related to the protection of the public's health;
- Morbidity and mortality data (international, national, state and local);
- The disease or situation being treated or vaccinated against;
- State specific priorities and unique needs.

The rank order of the target groups may be modified as resources and morbidity change. Special attention will be paid to educating the medical community and general public about the Target Groups, including the rationale for the rank order, how the decisions were made, and what other prevention measures people can take.

In addition to the Public Health Strike Force, pre-identified targeted groups might include:

- Laboratory personnel collecting or processing clinical specimens from confirmed, probably, or suspected patients.
- Health-care workers and public health personnel involved in the distribution of vaccine and/or prophylactic medication.
- Personnel who will work at mass clinic sites
- Personnel involved with direct medical or public health evaluation, care, or transport of confirmed, probable or suspected patients.
- Persons responsible for community safety and security (e.g. police and firefighters.
- Groups likely to come into contact with infectious materials (e.g. laundry workers, medical waste handlers)
- Highly skilled persons who provide essential community services (e.g. power plant workers, telecommunications and electrical grid operators)
- Translators
- Transportation services
- Medical emergency responders

For example, in August 2002, the Smallpox Advisory Committee, a Subcommittee of the Nebraska Bioterrorism Advisory Committee, met and made the following recommendations for pre-event smallpox vaccination in the state, based on 500 dose vial scenarios.

NEBRASKA – SMALLPOX PUBLIC HEALTH STRIKE FORCE	**DOSES NEEDED**
Deputy Chief Medical Officer	**1**
State Epidemiologist	**1**
Immunization Program/Disease Control Investigative Staff (1 Scottsbluff, 1 North Platte, 1 Kearney, 1 Verdigree, 6 Lincoln, 1 Omaha)	**11**
Disease Control – Program Manager	**1**
Immunization – Program Manager	**1**
Arturo Coto, HHSS Public Health Assurance: DXed Smallpox & Bilingual	**1**

Large Health Departments:Douglas and Lancaster Counties (15 doses each, identification of vaccine recipients determined at the local level)	**30**
Air Mobile Ambulance Services (30 doses) Confirm that if unable to fly vaccine reciepiants can travel on ground transportation otherwise prioritize to ground ambulance to assure coverage in all weather.	**30**
Nebraska State Patrol (6 doses)	**6**
Public Health Lab	**4**
Others With Potential Face to Face Contact (i.e.. Infectious Disease Specialists, Dermatologists, etc)	**60**
Translators	**24**
TOTAL	**170**

Smallpox Allocation	**500 Doses**
# of Doses Allocated	**Target Groups**
170	**Public Health Strike Team**
96	**Hospitals located in large Counties likely to receive referrals [Douglas (6), Sarpy (1), Lancaster (3), Hall (1),Buffalo (1),Adams (1), Lincoln (1),Scotts Bluff (1), Madison (1)] #6 doses per hospital**
222	**Health Care Providers located in 72 small counties (3 doses per hospital) and 6 doses for Indian Health Services (Winnebago, Macy, Santee)**
488	

Smallpox Allocation	**1000 Doses**
# of Doses Allocated	**Target Groups**
170	**Public Health Strike Team**
6	**Hospitals in large Counties likely to receive referrals: 6 doses per hospital [Douglas (6), Sarpy (1), Lanc. (3), Hall (1), Buffalo(1), Adams(1), Lincoln(1), Scotts Bluff(1), Madison(1)]**
222	**Hospitals in 72 small counties: 3 doses per hospital; 6 doses for Indian Health Services (Winnebago, Macy, Santee)**
250	**Medical Specialists to be allocated to hospitals per census**
	Essential Services
	Potential Targets
	Local and Regional Health Departments
45	**FBI & other Law Enforcement including tribal law enforcement**
200	**National Guard Security**

983

Smallpox Allocation	1500 Doses
# of Doses Allocated	Target Groups
170	Public Health Strike Team
96	Hospitals in large Counties likely to receive referrals: 6 doses per hospital [Douglas(6), Sarpy(1), Lancaster(3), Hall(1),Buffalo (1), Adams(1), Lincoln(1), Scotts Bluff(1), Madison(1)]
222	Hospitals in 72 small counties: 3 doses per hospital; 6 doses for Indian Health Services (Winnebago, Macy, Santee)
250	Medical Specialists to be allocated to hospitals per census
150	Essential Services
	Potential Targets
50	Local and Regional Health Departments
45	FBI & other Law Enforcement including tribal law enforcement
200	National Guard Security
300	Immunization Providers
1483	

Smallpox Allocation	Proposed Distribution of More Than 1500 Doses
Number of Doses Allocated	Target Groups
1500	Scenario for first 1,500 doses
500	Stockpile for immediate post-exposure vaccination of health care providers, family members
100	Community Health Centers
24	Lab personnel
24	Additional interpreters
Remainder	Distributed proportionally to hospitals, seeing 1% or more of state's patients, based on discharge summaries.
>1500	

2. During an event

   During an actual event, the targeted, high-risk category will also include persons exposed to the initial release. The high-risk category will include hospital and health care workers in facilities where contagious cases have been confirmed. Face to face contacts of cases, household, or close contacts may be considered high-risk depending on the scope of response as determined by technical staff investigating the outbreak.

   Each clinic planning region/local health department will maintain demographic information on the region and clinic contact personnel (Form 1: "Demographics – Clinic Planning Region"), pre-identified "High Risk/Immunize First" targeted populations (Form 2) and general population (Form 3: Population Characteristics – General Population). Regions may also want to generate and maintain information regarding area industries, businesses and capabilities (i.e. refrigerated storage facilities; trucking firms; schools; public auditoriums; media).

   All residents may be at risk depending on the biological or chemical agent used. For this scenario, general population estimates should be used to determine vaccine and/or prophylactic medication requirements by proposed clinic site. These estimates should be recorded in advance for each clinic site (Form 5). These estimates may differ throughout the year if an area has large transient populations (e.g. university students, seasonal workers). Since some of these fluctuations are predictable, they should be considered in the plan's estimates.

   Each region should plan for a high percentage of persons to attend clinics due to "fear factor". (Those from outlying or bordering areas will possibly replace the number of people in a community that choose not to attend clinic). Remember that depending on the event, distribution procedures will need to be evaluated in the presence of severe vaccine and/or prophylactic medication shortages, moderate shortages, and in the presence of no shortage.

   The summaries (Forms 2 and 3) will be used when estimating vaccine and medication needs. All regional information will also be forwarded to the central HHSS BT Response data file.

(Form 1) PUBLIC HEALTH RESPONSE PLAN
LOCAL HEALTH DEPARTMENT DEMOGRAPHICS

		PHONE
HEALTH DEPARTMENT NAME		
HUB CONTACT		

COUNTIES INCLUDED	LEOPS	PHONE

Primary Contact Name	Address	Home #	Work

Email Address	Cell/Beeper #	FAX

Secondary Contact Name	Address	Home #	Work

Email Address	Cell/Beeper #	FAX

Tertiary Contact Name	Address	Home #	Work

Email Address	Cell/Beeper #	FAX

Date Last Updated	

(Form 2)

Post Event (Disease Detected) Smallpox Response Plan

Population Characteristics – Immunize First

Organization	# of Personnel At Risk Immunize First	Estimated Number of Doses Needed
Immunization Clinic Staff		
Hospitals		
Private Clinics		
Pub. Health Personnel		
EMS		
Law Enforcement		
Fire Department		
Laboratories		
Translators		
TOTALS		

(Form 3)

Post Event (Disease Detected) Smallpox Response Plan

Population Characteristics – General Population

County	Population – County Census Data	College Students	Seasonal Workers	Other Groups Not Included in Census Data **	Total
TOTALS					

** Correctional facilities, mental health facilities, Job Corps, etc.

C. Security Considerations

Specific security needs should be formally assessed and incorporated into planning efforts to support large-scale vaccination programs. Provision of appropriate security should be made for the following: *(Refer to SNS protocol)*

- Vaccine storage sites (clinic and non-clinic) to include security personnel and locked, limited access areas for vaccine storage
- Backup power sources (generators) should be identified for all sites where vaccine is stored (vaccination clinics and storage sites).
- Vaccination clinic sites: security personnel for crowd control, traffic movement, clinic personnel safety, etc.
- Vaccine transportation to storage sites and dispensing clinics.

D. Clinic Site Selection

Each region should identify non-hospital locations where vaccine and prophylactic medications could be administered for case contacts and large numbers of the general public. Proposed sites should be visited before making final selections. For each site selected, prepare the following:

- Written plan for physical layout
- Clinic site selection criteria sheet (Form 4)

Schools or sports arenas are the preferred location for any clinic larger than what can be held in the local or regional health department. Schools have parking lots, long corridors, large classrooms, cafeterias, private offices, and other immediately available resources such as tables, chairs, restrooms, and offer an ideal physical structure that can meet most clinics needs. Other sites that may be considered include conference centers, large churches or temples, National Guard armories, or malls.

If the site does not have sufficient parking, offsite parking sites should be identified, with a plan that outlines how clients will be transported from the offsite lot to the clinic. (i.e. identification of vans or buses, drivers, schedules, etc.). According to the NE Dept. of Education, public school buses can be used for transportation to and from clinics. Clinic coordinators will need to work closely with the school administrators to set up this service.

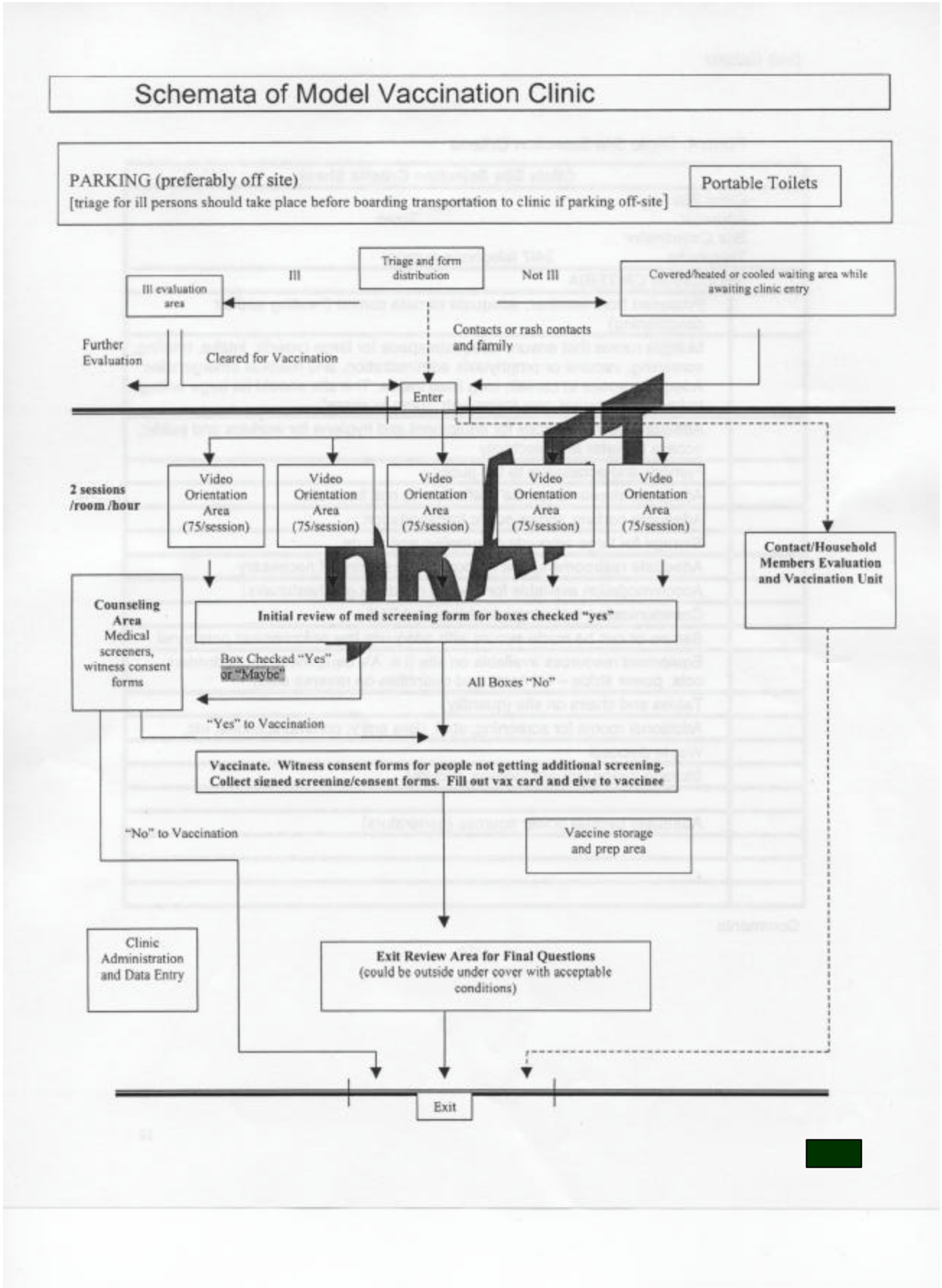
Other issues that need to be considered in the local plans include:

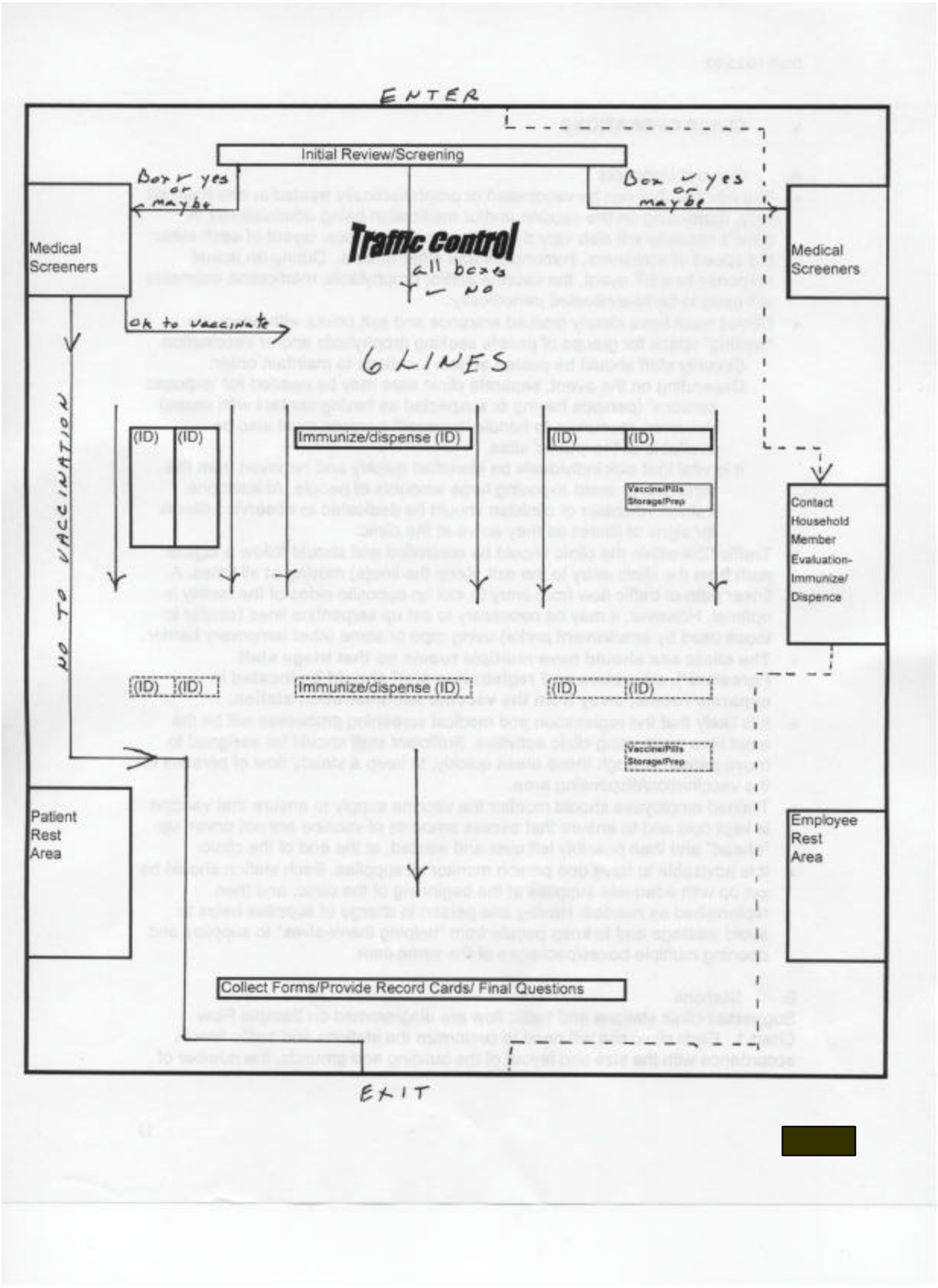
- How to vaccinate non-transportable populations (i.e. nursing homes, prisons, retirement communities)
- Whether to offer vaccination in high density residential units (i.e. apartment or housing complexes)
- Rest areas for clinic staff if staff may be working greater than 8-hour shifts

Form 4. Clinic Site Selection Criteria

Clinic Site Selection Criteria Sheet	
Clinic Site: Address: Town Site Coordinator Telephone 24/7 telephone number	
SELECTION CRITERIA	
	Protected from weather; adequate climate control (heating and air conditioning)
	Multiple rooms that ensure adequate space for large crowds, intake, briefing, screening, vaccine or prophylaxis administration, and medical emergencies. Adequate space to contain long lines inside. The site should be large enough to handle the target population with "room to spare".
	Adequate power sources for equipment and hygiene for workers and public; access to water and electricity
	Familiar and accessible to the public
	Adequate streets to handle traffic flow to and from site
	Adequate parking and/or public transportation
	Storage for large amounts of supplies and waste
	Adequate restrooms/space for portable restrooms if necessary
	Accommodation available for special needs (e.g. wheelchairs)
	Communication including telephone and FAX
	Secure or can be made secure with adequate law enforcement personnel
	Equipment resources available on site (i.e. AV equipment; room dividers, cots, power strips – list items and quantities on reverse side)
	Tables and chairs on site (quantity)
	Additional rooms for screening, staff, data entry, communications, etc.
	Waste disposal
	Storage space (square footage; secure)
	Adequate backup power sources (generators)

Comments


Schemata of Model Vaccination Clinic
PARKING (preferably off site)
[triage for ill persons should take place before boarding transportation to clinic if parking off-site]
Portable Toilets
Triage and form distribution
Ill
Not Ill
Ill evaluation area
Covered/heated or cooled waiting area while awaiting clinic entry
Further Evaluation
Cleared for Vaccination
Contacts or rash contacts and family
Enter
2 sessions /room /hour
Video Orientation Area (75/session)
Video Orientation Area (75/session)
Video Orientation Area (75/session)
Video Orientation Area (75/session)
Video Orientation Area (75/session)
Contact/Household Members Evaluation and Vaccination Unit
Counseling Area Medical screeners, witness consent forms
Initial review of med screening form for boxes checked "yes"
Box Checked "Yes" or "Maybe"
All Boxes "No"
"Yes" to Vaccination
Vaccinate. Witness consent forms for people not getting additional screening. Collect signed screening/consent forms. Fill out vax card and give to vaccinee
"No" to Vaccination
Vaccine storage and prep area
Clinic Administration and Data Entry
Exit Review Area for Final Questions
(could be outside under cover with acceptable conditions)
Exit
DRAFT


ENTER
Initial Review/Screening
Box ✓ yes or maybe
Box ✓ yes or maybe
Medical Screeners
Traffic control
all boxes ✓ — NO
Medical Screeners
ok to vaccinate
6 LINES
NO TO VACCINATION
(ID) (ID)
Immunize/dispense (ID)
(ID) (ID)
Vaccine/Pills Storage/Prep
Contact Household Member Evaluation- Immunize/ Dispence
(ID) (ID)
Immunize/dispense (ID)
(ID) (ID)
Vaccine/Pills Storage/Prep
Patient Rest Area
Employee Rest Area
Collect Forms/Provide Record Cards/ Final Questions
EXIT

V. CLINIC OPERATIONS

A. General Concepts

1. The directors of the local health departments have the overall responsibility for planning and overseeing all public clinics in their jurisdictions.
2. The directors of the local health departments need to identify a site administrator for each clinic, who will be responsible for overseeing and supervising the operations of that clinic.
3. The number of persons who can be vaccinated or prophylactically treated in one hour will vary, depending on the vaccine and/or medication being administered. A clinic's capacity will also vary depending on the physical layout of each clinic, the speed of screeners, speed and number of immunizers, language barriers, and other factors. During an actual response to a BT event, the vaccine and/or prophylactic medication estimates will need to be re-evaluated periodically.
4. Clinics must have clearly marked entrance and exit points with adequate "waiting" space for groups of people seeking prophylaxis and/or vaccination. Security staff should be posted at both locations to maintain order.
5. Depending on the event, separate clinic sites may be needed for 'exposed persons' (persons having or suspected as having contact with cases). However, resources to handle 'exposed' persons must also be available at the 'public' sites.
6. It is vital that sick individuals be identified quickly and removed from the clinic site to avoid exposing large amounts of people. At least one trained volunteer or clinician should be dedicated to observing clients for signs of illness as they arrive at the clinic.
7. Traffic flow within the clinic should be controlled and should follow a logical path from the clinic entry to the exit. Keep the line(s) moving at all times. A linear path of traffic flow from entry to exit on opposite sides of the facility is optimal. However, it may be necessary to set up serpentine lines (similar to those used by amusement parks) using rope or some other temporary barrier.
8. **The clinic site should have multiple rooms so that triage staff ('greeters'), educators and registration staff should be located in separate rooms, away from the vaccine administration station.**
9. It is likely that the registration and medical screening processes will be the most time-consuming clinic activities. Sufficient staff should be assigned to move person through these areas quickly, to keep a steady flow of persons to the vaccination/dispensing area.
10. Trained employees should monitor the vaccine supply to ensure that vaccine is kept cold and to ensure that excess amounts of vaccine are not drawn up "ahead" and then possibly left over and wasted, at the end of the clinic.

11. It is advisable to have one person monitor all supplies. Each station should be set up with adequate supplies at the beginning of the clinic, and then replenished as needed. Having one person in charge of supplies helps to avoid wastage and to keep people from "helping themselves" to supplies and opening multiple boxes/packages of the same item.
12. Clinics will have designated lines for children, persons with ambulatory problems, persons who faint when given injections, or other special circumstances.

B. Stations

Suggested clinic stations and traffic flow are diagrammed on Sample Flow Chart 1. Each clinic site will need to customize the stations and traffic flow in accordance with the size and layout of the building and grounds, the number of clinic staff available and their skills, and the targeted number of clients to be served per hour.

1. Triage and Initial Screening

   Trained volunteers or clinical staff quickly interview clients, as they arrive at the site.

   a. Separate and direct clients to the appropriate station according to the following:
      1) Registration and Sign-In

         Well persons who fit the eligibility criteria. Signs should be posted at the entrance, listing eligibility criteria and contraindications.
      2) Medical Station
         - Females who are or may be pregnant;
         - Persons who state that they have a medical condition that may be a contraindication for vaccination and/or prophylaxis. Post signs, listing contraindications.
         - Those with suspected illness and symptoms are directed <u>immediately</u> to the Medical Station. When appropriate, standard precautions (face masks, gloves, etc.) should be followed in accordance with EMS and HAZMAT guidelines.
         - Those with documentation of previous prophylaxis and/or questionable immunization history

   b. Well individuals are provided educational material and consent forms and directed to the education/video orientation rooms. These rooms are the first point of entry for clients seeking administration of vaccine and/or prophylactic medication.

2. Education/video orientation rooms, if applicable

   a. Persons must show the 'gate keeper' their educational materials and consent form (which doesn't have to be completed yet) to enter the education/video orientation rooms.
   b. 'Gate keepers' will stamp clients' hands as they leave the rooms, verifying that the persons have been provided the education information.

   c. Instruct clients to carefully read and complete the Information Form/Request to Receive Vaccine and/or Prophylactic Treatment and have it ready to present at the Medical Screening and Registration station.
3. Medical Screening and Registration
   a. Establish eligibility to receive vaccine and/or prophylactic medication. Review address, identification, referrals, or any information needed to determine eligibility;
   b. Conduct counseling and review of the most current Information Statements; two-way verbal communication is essential to obtain informed consent, especially with non-English speaking individuals.
   c. Discuss precautions and contraindications prior to administration, according to the latest CDC recommendations.
   d. Ensure signature/documentation of consent.
   e. Refer to Vaccination/Prophylaxis Administration Station or to Medical Station if there are questions.
4. Vaccination/Prophylaxis Administration Station
   Vaccination and/or prophylaxis administration takes place at this station.
   a. Assure counseling was given to client prior to administering vaccine and/or prophylactic medication.
   b. Verify that there are no contraindications to receipt of vaccine or prophylactic treatment.
   c. Administer the vaccine or prophylactic medication in accordance with established protocol. (See Annexes for information on specific vaccines and treatment drugs.)
5. Post-vaccination/post-treatment station
   Provide the recipient with documentation of vaccination and/or prophylactic medication.
   a. Give instructions regarding importance of completing medication, or returning for additional doses of vaccine. Inform patients of tracking/recall procedures.
   b. Provide recipients with Standing Orders and if appropriate, an Emergency Kit, for possible reactions to vaccine/first dose of medication. (See disease-specific appendices).
6. Vaccine/Medication Prep Area
   Staff prepares vaccine for administration;
   a. Staff stock the Vaccine/Prophylaxis Administration Station.
   b. Staff repackages medications into individual doses/quantities.
   c. The Supply Manager or Pharmacy Manager maintains a centralized inventory of vaccine and/or prophylactic medication, and other supplies.
   d. The Supply Manager or Pharmacy Manager ensures that all stations are continually stocked with adequate inventories of all necessary supplies.
7. Medical Station
   a. The following persons are referred to the Medical Station:

1) Persons with possible contraindications to vaccines or prophylactic treatment drugs;
2) Persons with a recent history of selected illnesses or who may currently be ill;
3) Persons who have medically related questions that can not be answered by the Registration Staff.

b. The Site Physician/Physician's Assistant/Certified Nurse Practitioner will assess the clients regarding administration of the vaccine or treatment drug. Clients may be referred to their private health care providers for a more comprehensive assessment.
c. Arrange for ill clients to exit the building through an identified exit that is not part of the clinic flow pattern.
d. If appropriate (See Disease-specific Annexes), arrange for transportation to the nearest care facility with the least exposure to other clients.
e. Persons who suffer a medical emergency are treated at the medical station. An emergency kit and supplies, and ambulance are on site for medical emergencies.
f. Medical Station staff will maintain a record of persons seen, reasons for a the assessment and action taken, including basic identification and demographic information, in case there is a need to contact the client at a later time. (See Form 6)

8. Interpretation Station

Assist persons who are unable to read and/or write English;
If the person does not speak English, assist as needed in reading, writing and/or interpreting.
Provide information in foreign languages and provide interpreters to ensure that the clients understand the information, are appropriately screened and complete all necessary documentation.
Interpreters may need to accompany non-English speaking persons through the clinic.

a. Interpreters may be placed strategically through the clinic to ensure that there is assistance as needed.

Form 6

Mass Clinic Medical Station Referral

Patient Assessment Information

Date_____Time_____Clinic Site_____
Patient Name (first, last)_____DOB_____
Patient Address (St./Box; Town, State)_____
Telephone (work)_____home_____cell_____
Reason for assessment_____
Action taken_____
Attending practitioner (print)_____
Signature _____
(Triplicate form: Original – clinic site; 2nd copy – patient; 3rd copy – for referral provider/patient's physician

C. Supplies and Equipment (Storage, dispensing, security measures, quality control and accountability will be consistent with the SPS plan)
HHSS will identify a State central storage site and regional supply storage facilities, consistent with the SNS plan (hubs and sub-hubs). The State will store supplies and pharmaceuticals, based on volume, perishability, how easy it is to obtain an item and ease of redistribution. Supply managers will be identified at the State, regional hubs, sub-hubs and clinic sites to oversee storage and redistribution. Vaccine, medication and supply distribution and redistribution in each region will be done with direction from HHSS and Emergency Management.

Depending on what supplies are furnished by the Federal Government, NE HHSS will provide hubs, subhubs and local health departments further direction regarding what supplies will be stored at the State and regions, and distributed to them and what supplies they need to maintain, or have reserved locally.

State and regional responsibilities:

1. Ensure personnel and protocols are in-place for quality assurance: monitoring and maintaining appropriate storage temperatures, checking lot numbers and expiration dates.
2. Establish contacts and procedures for obtaining all other necessary supplies within 24 hours of an emergency. HHSS will obtain memorandums of understanding with suppliers.
3. When appropriate to facilitate the delivery, storage and set-up of materials in the clinic area, share clinic site plans, clinic flow charts, and other anticipated needs, in advance, with managers at identified clinic sites (i.e.

school administrator), clinic staff, suppliers and other collaborative partners.

4. Establish inventory control systems. (See Form 7 for list of possible supplies.)
5. HHSS will use the current inventory management inventory system to track vaccines and prophylactic drugs.
6. Staff will monitor supply distribution based on available information about the scope of response, clinic capacity, and existing on-site inventory. The supply manager is responsible for maintaining inventory and monitoring its distribution. Supply managers should be trained in advance on procedures for ordering supplies and maintaining inventory. The correct procedures for handling medications and vaccines should be emphasized.
7. HHSS will work with private trucking firms to use dedicated trucks, staff, and drivers and preplanned routes to deliver supplies to identified storage and clinic sites.
8. HHSS will obtain required forms (Vaccine/Drug Information forms; vaccine records; Contraindications, etc.) from CDC or HHSS will make arrangements for printing locally.

Form 7 **Advance Planning Supply List for Regions**

Date Received	Quantity	ITEM
		VACCINES/PROPHYLACTIC DRUGS
		(specify)
		INFORMATION MATERIALS
		Informed consent slips
		Vaccine/Drug Information Statements (VDIS)
		Orientation videos
		Contraindication information
		Adverse event diary
		Vaccine Adverse Event Report (VAERS) forms
		Reminder/recall/vaccine "take" cards for clients—specific to Vaccine/Prophylactic Medication being administered
		Small pox
		Anthrax
		Influenza
		CLINICAL SUPPLIES
		Biological waste containers (i.e. 12 gallon size)
		Syringes
		(specify size)
		Needles
		(specify length & gage)
		Sterilized bifurcated needles (smallpox clinics)
		Latex gloves
		Size: sm.
		Med
		Lg
		Latex-free gloves
		Size: sm.
		Med
		Lg

Date Received	Quantity	ITEM
		Alcohol wipes
		Acetone
		Spot band aids
		Rectangle band aids
		4” by 4” pads
		Electronic thermometer
		Table pads/paper rolls to cover tables
		Paper to cover tables
		Antibacterial hand washing solutions
		Paper towels
		Portable coolers for transport/handling of vaccine
		Cooler size
		Gauze
		Adhesive tape
		Bleach solution and spray bottle
		Acetaminophen elixir samples
		Acetaminophen drops samples
		Acetaminophen children’s chewable (80 mg)
		Acetaminophen adult tablets
		Pill-counting machines and/or trays (if needed)
		Pill Bottles and Lids
		Drug counting Spatulas
		Labels
		Reusable ice packs (3-5 per station)
		Emesis basin
		Asthma inhaler
		EMERGENCY KIT
		Copies of Standing orders and protocol for emergencies
		Ampules epinephrine 1:1000 SQ or Epi Pen

Date Received	Quantity	ITEM
		Ampules diphenhydramine (Benadryl) 50 mg IM
		3cc syringes with 1", 25-gauge needles
		1 ½" needles
		Tuberculin syringes with 5/8" needle, for epinephrine
		0.9% Sodium Chloride
		5% Dextrose
		IV Starter Kits (solution and tubing)
		Spirit of ammonia
		Alcohol swabs
		Tongue depressors
		Pediatric pocket mask with one-way valve
		Adult pocket mask with one-way valve
		Pediatric airways
		Adult airways
		Tourniquets
		Oxygen tank with tubing
		Gurney
		Stethoscope
		Blood Pressure Cuff (Adult and pediatric)
		Cots
		Blankets
		Pillows
		Kleenex tissues
		ER report form *(Develop)*
		PAPERWORK AND OFFICE SUPPLIES
		Copies of standing orders for vaccines and prophylactic medications
		Small pox
		Anthrax
		Influenza
		Regional contact list (multiple copies)

Date Received	Quantity	ITEM
		Signage (English, Spanish, and other languages)
		External—entrances and exits
		Internal—Clearly marked areas, lines, stations
		Biohazard
		Contraindications posters
		Other posters specific to vaccines and prophylactic medication
		Public information materials in English, Spanish, and other languages
		Screening questionnaires
		PSA regarding appropriate attire to receive vaccine (i.e. short loose sleeve)
		Hand Truck/Dolly
		Small two tiered cart for moving supplies
		Janitorial supplies (mop, bucket, broom, etc.)
		Box cutters
		Calendars
		Sound systems
		Sound barriers
		Clipboards
		Pens (for clinic staff and clients)
		Envelopes
		Size
		Blank paper
		Rubber bands
		Tape
		Post-it notes
		Date stamps
		Paper Clips
		Staplers/staples
		Scissors
		Boxes for storage and transport
		File boxes

Date Received	Quantity	ITEM
		MISCELLANEOUS MATERIALS
		Refrigerators
		Refrigerator capacity: Sq. Ft. _____
		Backup generators
		Garbage containers and trash bags
		Cell phones, Extra plug-in telephone
		Two-way radios
		Pagers
		Tables
		Chairs
		Drinking water and cups
		Photocopy machine
		FAX machine
		Computers and internet access
		IDs for staff
		Name tags
		Identifying clothing (i.e. baseball caps)
		List of emergency phone numbers
		VCR or DVD player (for client education)
		Radio (preferably with at least one hand crank radio or radio with extra batteries)
		Flashlights and extra batteries
		Yellow "caution" tape or something similar to define waiting lines/areas
		Room divider screens

D. Personnel and Logistics

Recruit clinic coordination staff in advance. Coordination staff include persons, paid and volunteer, who will oversee specific activities, oversee supporting staff, and/or oversee more complex tasks (i.e. screening). Clinic site information, including coordinating personnel, should be summarized on Form 5. This information should be on file with the local health department, the LEOP and NE HHSS.

Form 5

Mass Clinic Site Information Sheet

Region_____ Location (i.e. Norfolk High Gym)_____
Site Street Address_____Town_____Co____
Site Telephone:_____Site Fax:_____
Site Coordinator (24/7 contact)_____
Telephone: Home_____Work_____Cell_____

Estimate of Target Population_____ Estimated Site Capacity_____
Estimate of number that can be vaccinated per hour (based on capacity)_____
Days Required to Vaccinate Target Population_____

Clinic Personnel (Name)	**Phone #1**	**Phone #2**	**Cell**
Med. Dir.			
Nurse Manager			
Supply Manager			
Clinic Security			
Volunteer Coord.			
Translator			
Others (i.e. sanitation, EMS)			

Comments

Staff will receive training from state and local health department personnel on the overall clinic operations and the specific task(s) that they will be responsible for. 'Mock clinics' will be held at regional locations across the state to provide education and hands-on experience. ('Mock clinic' settings will be used when administering pre-event smallpox vaccine.) Staff will also be provided with clinic manuals and/or job descriptions, outlining their responsibilities. Training will also be provided for other staff that will take on clinic related activities but who may not actually be working in the clinics. (I.e. staff assigned to answer hotlines, process paper work from clinics, and carry out other "normal" public health functions)

1. Administrative Personnel
   Depending on scope and size of the response, significant administrative resources may be needed to process 'doses administered' forms, vaccination records (including data entry), and information requests from the medical community and the general public. Policies must be in place for awarding compensatory time and/or paying overtime. New priorities for duties and responsibilities must be established and communicated to front line staff as quickly as possible.

   Administrative personnel can use Form 8 **Personnel and Logistics – Advance Planning Checklist** to guide them in preparation and implementation.

2. Clinic Personnel
   Assumption: Administration of vaccine and/or prophylactic medications are very labor intensive. Some vaccines and medications are more labor intensive than others (i.e. measles vaccine can be administered more quickly than smallpox vaccine). See disease-specific appendices for estimates of the manpower needed to operate a mass clinic.

3. Clinic Job Role Descriptions
   a. Site administrator: Responsible for overseeing and supervising all operations of the clinic. The director of the local health department will appoint the site administrator.
   b. Primary media contact: All media questions are referred to this person. This person may be the site administrator or may have other assigned responsibilities. The director of the local health department will assume this responsibility or may assign it.
   c. Site Physician/Physician's Assistant/Certified Nurse Practitioner: Final authority on all medical questions.
   d. Nurse Clinic Manager: Assigns/directs all those administering vaccines and prophylactic medication; assists on-duty staff at all stations (e.g. vaccine/prophylactic medication, sick, and screening) as needed.

e. Pharmacy Manager: Oversees repackaging of all medications and all other pharmacy related activities. In charge of vaccine/prophylactic preparation station.
f. Supply Manager: Ensures adequate vaccine/prophylactic medications and supplies are taken to the clinic site. Maintains all supplies in a temporary "warehouse" on site and maintains vaccine cold-chain. Issues supplies/vaccines to supply distributors as required. Sees that all unused supplies and vaccines are transported back to point or origin and properly stored.
g. Security Coordinator: Oversees personnel assigned to security activities at the clinic site; assists the clinic manager in making duty assignments of security personnel; determines appropriate number of security staff necessary according to clinic size and location; maintains a list of authorized clinic staff and their phone numbers; assigns and coordinates use of cell phones and pagers; establishes staff check-in and check-out procedures; ensures all staff wear **ID badges**; maintains communication with local law enforcement and EMS officials.
h. Volunteer Coordinator: Oversees volunteer activity at the clinic site. Coordinates recruitment and training of volunteers. Provides job descriptions and defines roles/responsibilities. Maintains volunteer roster and activates volunteer network when needed. Maintains accurate records of volunteer hours.
i. Medical Gatekeeper: Assist security in assessing clients as they first arrive at the clinic site. Should be a highly trained volunteer or clinician who screens for obvious signs of illness. Directs sick persons to Medical Station or arranges transportation to primary care site.
j. Medical Station Staff, including Site Physician/Physician's Assistant/Certified Nurse Practitioner and paraprofessionals:
    1) Evaluate clients who may have possible contraindications to vaccine and determine whether the client can receive the vaccine and/or prophylactic medication or whether the client needs to be referred to his/her primary care provider for further evaluation.
    2) Evaluate persons who are or may be ill to determine whether the client can receive the vaccine and/or prophylactic medication or whether the client needs to be referred to his/her primary care provider for further evaluation. If the client may be ill with a reportable communicable disease or condition that may need additional follow-up, obtain basic information on the client and illness/condition (Form 6) and forward the information to designated Disease Investigation Specialists (DIS) for further investigation.
    3) Answer medical questions. When necessary perform physical examination of patients who state they may be or are ill or who may have conditions that may constitute contraindications.
k. Triage/Greeters: Greet and conduct initial orientation of potential Vaccine/Prophylactic Medication recipients upon their arrival; provide basic information (verbally or with a video presentation) ; distribute

informational material and forms to be filled out. Send ill persons, persons with recent case contact, or persons with possible contraindications to vaccine and/or prophylactic medication to the Medical Station.

l. Registration Staff: Review each vaccine recipient's forms for completeness and accuracy; assist clients with completing documents. Send ill persons, persons with recent case contact, or persons with possible contraindications to vaccine and/or prophylactic medication to the Medical Station.
m. Immunizers/Administrators/Witnesses: (Nurses, EMS personnel, Physicians) Verify that there are no medical contraindications to vaccination and/or receiving the prophylactic medication. Vaccinate and/or administer the medication; complete HHSS documentation of administration (See Appendices for documents). Sign or provide the client with verification of administration. Observe vaccine recipients for immediate reaction or complications. Each administration table is staffed by immunizers/administrators and 'witnesses'. The witnesses and the administrators trade off responsibilities; the administrators become witnesses and the witnesses become the administrators. This assures that the administrators do not become fatigued and that there is sufficient 'back-up' and assistance for any unusual or emergency situations.
n. Immunizer Assistants: Assist the immunizer with all aspects of pre- and post- vaccination and/or prophylactic medication administration activities. Ensure that administration station maintains adequate supplies; if necessary, assist recipients in preparing the vaccination site (i.e. roll up sleeve, remove arm from shirt/blouse); clean vaccination site, if necessary; apply dressing to the vaccination site; instruct clients about care and changing of the dressing; possible side effects and treatment of the side effects, etc.
o. Post-immunization: Provide the recipients with records of vaccination/treatment. Ensure that recipients have been provided information on possible side effects, care of injection sites, pain-fever management related to vaccine side effects, emergency contacts, and any other related information.
p. Forms Collectors: Verify that forms are correctly completed; collect all necessary forms from recipients before departure.
q. Supply Distributor(s): Obtain supplies from Supply Manager to keep vaccination/administration stations adequately supplied. Also, transports pre-drawn syringes or measured doses from the "mixing station" to the Immunizers as needed (if this method is used in the clinic).
r. Crowd Controllers: Personnel should be stationed every few yards along waiting lines to distribute Vaccine Information Statements (VISs), answer questions, monitor clinic flow, and check for ill persons.

s. Security: Ensure an orderly flow of traffic and parking at the clinic site; assist in maintaining orderly movement of Vaccine/Prophylactic Medication recipients through the clinic; provide necessary control if persons become unruly; assist supply officer in maintaining security of prophylaxis medications/vaccine and other clinic supplies.
t. EMS: Local EMS should be on site during clinics to respond to medical emergencies.
u. Recovery Area Staff: Available to client who is faint or having a reaction to a vaccine; assess client condition and provides care as needed.

4. Role of Volunteers
Volunteers are a critical resource and can perform a variety of functions.
   a. Triage:
   Help separate people to be vaccinated and direct to appropriate areas.
   b. Registration and Sign-in:
      1) Document name of person. Confirm review of the current VIS.
      2) Have individuals sign-in on clinic roster.
      3) Ensure that client information is completed.
      4) Conduct preliminary screening related to contraindications.
      5) Direct to appropriate vaccination station;
      6) Or if there are medical or other questions, refer the client to the Medical Station.
   c. Vaccine/Administration
      1) Translate for staff.
      2) Assist in completing prophylaxis/vaccination records.
      3) Encourage individuals to keep records on their person at all times.
      4) Inform individuals about vaccine “take” and any additional doses needed of medicine/vaccine.
   d. Medical Station
      1) Obtain general identification information from client, such as demographics and condition needing further assessment (Figure 6).
      2) Provide translation as needed.
   e. Interpretation Station
   Staffed by trained volunteers, fluent in foreign languages, who:
      1) Assist persons who are unable to read and/or write English;
      2) If a person does not speak English, assist as needed in reading, writing and/or interpreting.
      3) Provide information in foreign languages and provide interpreters to ensure that the clients understand the information, are appropriately screened and complete all necessary documentation.
      4) Interpreters may need to accompany non-English speaking persons through the clinic.
      5) Interpreters may be placed strategically through the clinic to ensure that there is assistance as needed, throughout the clinic.

5. Support Personnel
   Support personnel may include fire fighters (including HAZMAT), law enforcement, private suppliers (portable restrooms, tables, chairs), courier services, data entry, mail delivery (US, UPS, FedEx.), laundry services, medical supply companies, hospital and private clinic personnel, public transportation management and workers, and sanitation workers.

Form 8 **Personnel and Logistics—Advance Planning Checklist**

	Update and maintain call lists for each Regional and Local Health Office and Regional Trauma Units: Medical (MDs, nurses, EMTs, PAs, pharmacists, social workers) • Logistical (clerks, record keeping, materials and supply management, messengers/couriers, people movers) • Communication • Security (police, military, traffic control) • Volunteers
	Follow BT plan for command structure and operations: medical, logistics, communications, and security. Follow command structure with clear delineation of assignments and responsibility.
	Assess current partnerships with organizations (i.e. Emergency Management, Private Healthcare, Skilled Nursing/Long Term Care, Human Services, Schools, Business and Industry, Media, Voluntary Organizations, Hospitals, Home Health)
	Follow job descriptions as outlined in BT plan
	Adapt set-up diagrams for regional clinics, showing location of personnel by job title
	Ensure that the proper chain of authority and contact is set up in accordance with the bioterrorism planning department. Establish local contact for clinic sites.
	ID Badges – Print, distribute to all staff (need badges, lanyards, sign-in and sign-out sheet of personnel)
	Ensure that all non-health department personnel administering vaccine/prophylactic medication such as volunteers are working under the auspices of the regional office.
	Establish policies and financial support to ensure personnel will be fairly compensated for working overtime
	Establish back-up plan for provision of "regular" public health services in the event of personnel reduction in force
	Ensure availability of translators for all levels of clinic (i.e. security, screeners, nurses, emergency)
	Ensure that appropriate personnel attend advance training sessions (i.e. smallpox vaccination, VAERS, precautionary measures and guidelines)
	Review security procedures for vaccine distribution and storage. Review procedures for vaccine/prophylactic medication transport.

	Develop security plans for crowd control, traffic control, clinic personnel, materials/supplies/equipment at each clinic site.
	Develop plan to transport workers, supplies/materials/equipment to clinic
	Develop procedures for transferring sick people to a definitive care site if necessary
	Review public transportation system, and other issues related to clinic access
	Establish procedures for the distribution of medications to people that cannot come to the mass medication dispensing centers (can a family member obtain medication for children at home or for an invalid family member)
	Establish procedures for segregating sick people from exposed but asymptomatic people at clinics
	Develop Quality Assurance plan
	Assure adequate staff to use the LINKS system for tracking, follow-up, and recall if necessary
	Develop procedures for shutting down clinic

E. Emergency Protocol

Each clinic site should have an ambulance, appropriate equipment and treatment drugs, and emergency response personnel on site. Sites will use established EMS protocol to respond to emergencies at the site.

Need to develop specific emergency protocol to address allergic reactions, fainting, heart attack, other medical emergencies.

VI. TRAINING

Advance training is vital to ensure a coordinated and appropriate response. NE HHSS will use a combination of techniques to train clinic staff across the state, including “train the trainer’ sessions, self-study modules, videos, written instructions, satellite sessions, face to face lecture and “hands on” experiences. Staff turn-over is an issue and therefore, to the degree possible, local and regional response agencies will be provided access to training materials. In addition, training updates will be needed to ensure that personnel have the most up-to-date information and protocol.

NE HHSS will identify individuals to participate in appropriate CDC “train the trainer” activities, who will then oversee the training of local staff, using CDC and Nebraska-specific materials. The following modules are being developed to

address general mass clinic operations. Event-specific information and training are included in the annexes. *Need training calendar and training manual.*

Form 9 **Training Modules**

	TRAINING MODULES
	Disease/event overview, including transmission, communicability, scope of threat, vaccine/treatment drug side effects and contraindications – All staff
	Scope of Response/Control Measures—Epidemiologists, Physicians
	Inventory and Control—Supply Managers, Centralized Admin. Personnel, Immunizer Assistants
	Vaccine/Prophylactic Medication Administration—Physicians, Nurses, Pharmacists, Immunizer Assistants
	Screening, Registration—Medical screeners, Registration Staff, Forms Collectors
	Vaccine/Prophylactic Medication Management—Supply Managers, Physicians, Nurses, Pharmacists
	Clinic Management—Physicians-in-charge, Nurse Clinic Manager, Pharmacy Manager
	Security—Physician-in-charge, Nurse Clinic Manager, Pharmacy Manager, Crowd Controllers, Security Staff (law enforcement), Transportation Support Staff
	Emergency Procedures—ALL
	Vaccine Safety—Physicians, Nurses, Pharmacists, Immunizer Assistants, Medical screeners

VII. PUBLIC EDUCATION

- Use national, local and educational TV, radio networks and the NE HHSS web site to present uniform messages. Planners should consider how these messages could be quickly developed, locally, to accommodate sudden changes in sites and/or recommendations.
- On the NE HHSS website, post information and forms that the public can read prior to the clinic. Consent forms can be printed off and brought to the clinic. Other items of information might include vaccine information statements, consent forms, “take” information, contraindications, those who should not come to a mass clinic, adverse events.
- Provide the same information on the web site to the print media for dissemination in newspapers.
- Consider the use of the faith community (i.e. churches) and public forums to educate the public.

- Establish lists of non-English speaking media outlets that can be used to deliver messages to immigrants/refugees and other non-English speaking communities.
- Provide
- Messages (videos, tapes, press conferences, experts)
  - Pre-Event BT Messages – Advising population on various BT diseases and prevention and treatment messages; preparatory steps being taken by the health department (1 million in 10 day vaccination plan); methods to be used to inform public in case of impending event; outline of health department plan if an event occurs; adequacy of vaccine supply.
  - Event Messages
    State plan that is being put into operation, including:
    - urgency and patience, but not panic;
    - plan regarding number of mass clinics;
    - timing to prevent smallpox;
    - vaccine supply;
    - trained personnel;
    - listing of collection areas where people will be picked up by buses;
    - materials required to prove eligibility for admittance into clinic, if any;
    - listing of normal activities being suspended;
    - hotline numbers;
    - review of vaccine recommendations;
    - local information regarding targeted populations and clinics (i.e. who, what, where, when, why, persons/numbers to contact if questions)
    - frequently updated “wait-times” for vaccination clinics via multiple communication outlets (e.g., local television)

VIII. Summary of Planning and Response Steps

In this chart, do we want to indicate who is responsible for the action?

	Action
	Investigate outbreak and determine scope of response.
	Select sites and times for high-risk clinics. Use contact lists to activate clinic personnel.
	Select sites and times for general populations clinics. Use contact lists to activate clinic personnel.
	Fill out clinic supply lists (see figure 6) based on population estimates at each clinic site.
	Order vaccine/prophylactic medication and necessary supplies.
	Arrange delivery of supplies to clinics.
	Activate security plan to protect supply depots and deliveries of clinic supplies.
	Through appropriate channels, Inform media partners of scope of response; date, time, location of clinics. Also, appropriate clothing if vaccination being given. Reassuring message that all possible measures are being taken to prevent further spread. State clearly what criteria are for whom will/will not be accepted for prophylaxis/vaccination.
	Conduct clinics for high-risk personnel.
	Fill out daily tally sheets at each clinic and submit to centralized supply depot and/or immunization program.
	Consolidate daily tally sheets onto one doses administered form and submit to LOPH/Immunization.
	Conduct clinics for general population.
	Fill out daily tally sheets and supply orders at each clinic and submit to centralized supply depot and/or immunization program.
	Consolidate daily tally sheets onto one doses administered form and submit on regular intervals to HE HHSS.
	Monitor inventory levels and re-order supplies as necessary.
	Conduct random checks of clients to ensure vaccine take.
	Arrange re-vaccination clinics if necessary.
	Evaluate effectiveness of clinics and overall response.
	Update policies and procedures based on experience and feedback from participants.

IX. References, Attachments and Generic Forms

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IX. REFERENCES, ATTACHMENTS AND GENERIC FORMS

A. General
   - *To the degree possible, generic forms are being drafted that can be used for any mass clinic situation. We are starting with smallpox specific forms and information and will amend accordingly.*

   To be developed:
   - Signs to direct clinic flow
   - Posters announcing clinic dates, times, locations
   - Summary of doses administered per clinic site and date
   - Staff confidentiality pledge (required for payroll and volunteer staff)

B. Other
   - Local Health Departments
   - Strategic National Stockpile

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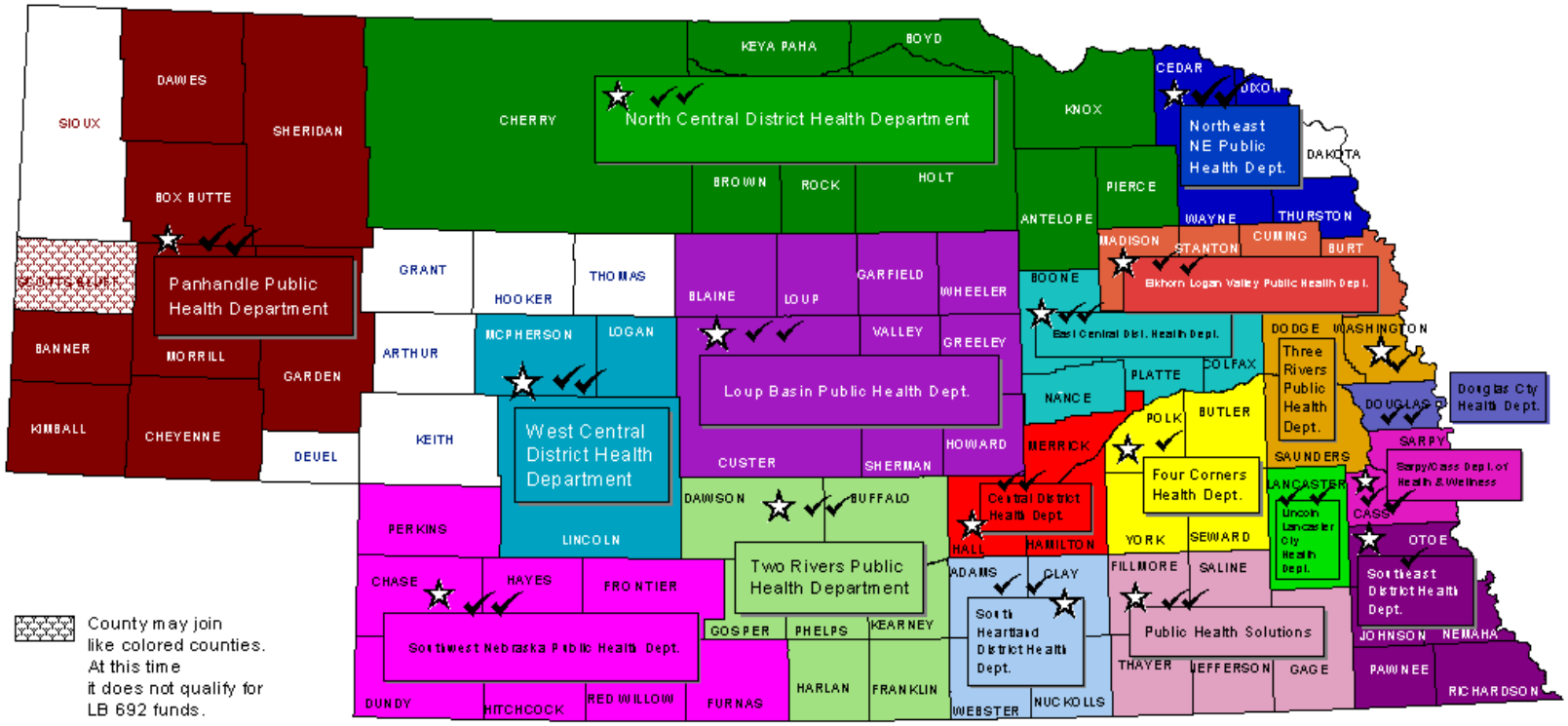
Nebraska
Local Health Department
Formation



County may join like colored counties. At this time it does not qualify for LB 692 funds.

White colored counties at this time do not qualify for LB 692 funds.

Indicates a new district health dept. since the passage of LB 692.

Board of Health has been formed.

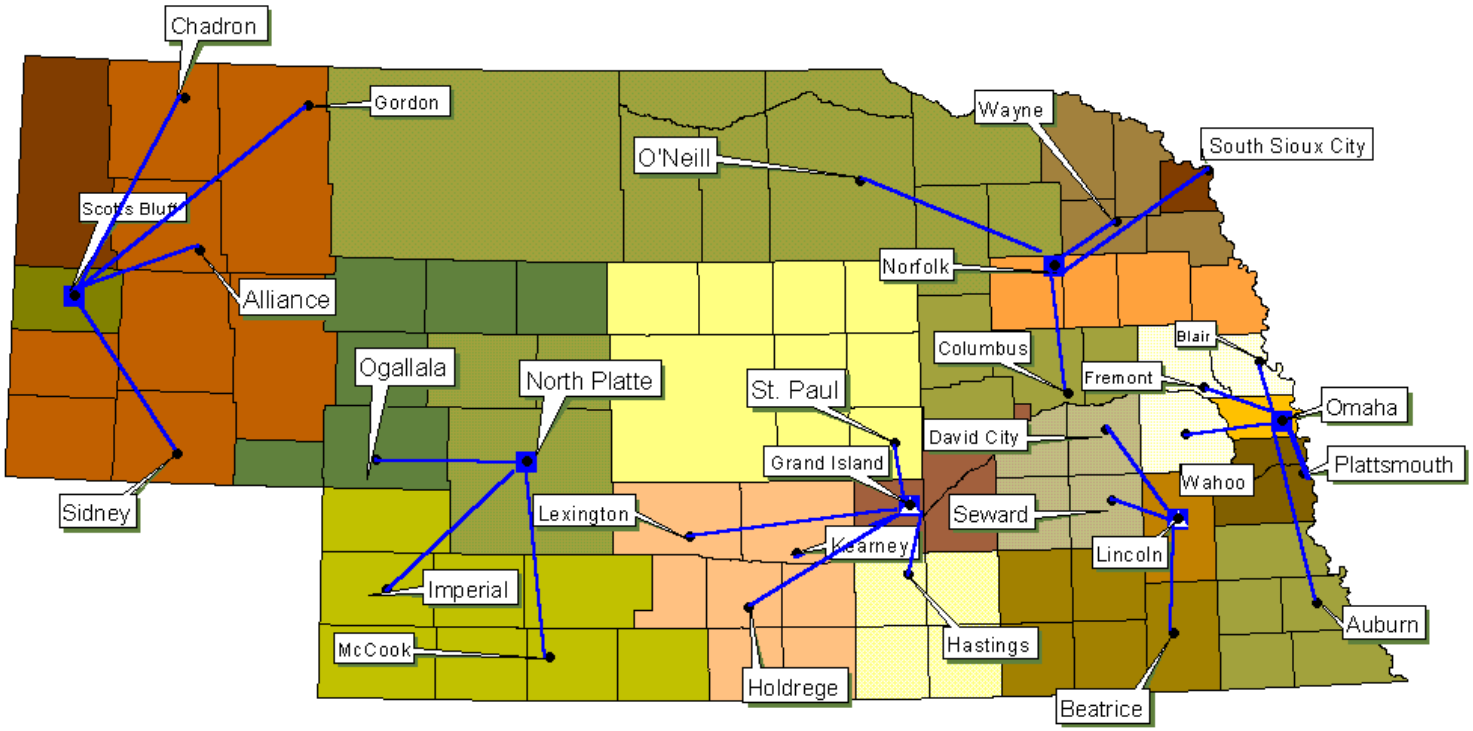
Board of Health has been formed and a Director hired.

Current as of November 18, 2002

LB 692 passed during the 2001 Legislative Session provides infrastructure and per capita funds to local health departments.

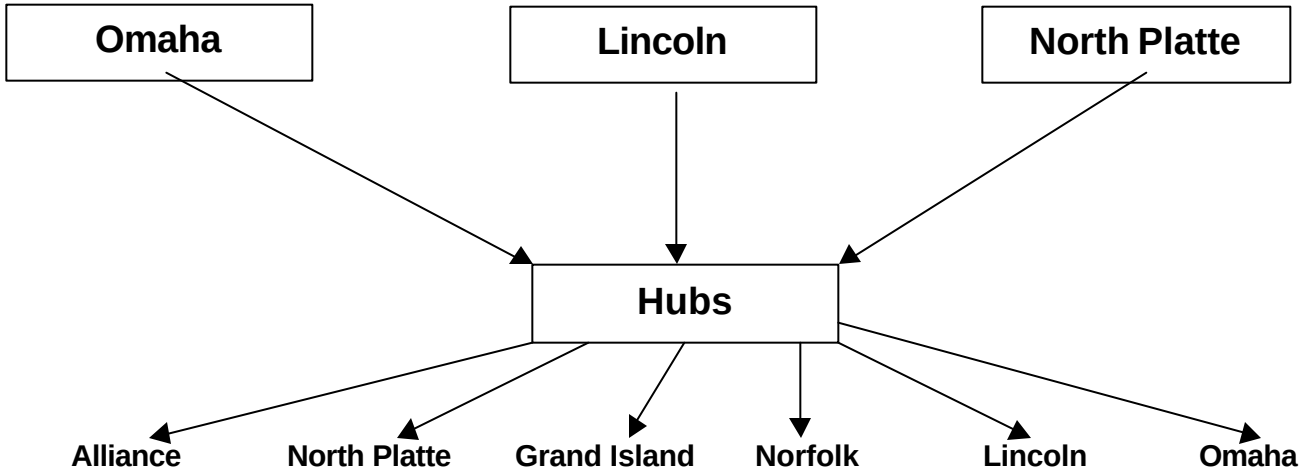
HHS, Office of Public Health, Sue Medinger

National Pharmaceutical Stockpile
Nebraska Distribution Map



Strategic National Stockpile
Landing and Distribution

Landing Sites



Sub Hubs

Chadron	Lexington	Hastings	Columbus	Beatrice	NE City
Scottsbluff	Ogallala	Kearney	Sioux City	Seward	Plattsmouth
Rushville	McCook	Loup City	Wayne	David City	Fremont
	Valentine	Holdrege	O'Neill		Wahoo
	Sidney				Falls City

ANNEX A SMALLPOX

ANNEX A: SMALLPOX

INTRODUCTION

ANNEX A: Smallpox describes in more specific detail, the logistics, design and implementation of voluntary, large-scale, post-event smallpox vaccination clinics. Personnel need to apply the general guidance contained in *the general guidelines* and the specific guidance contained in Annex A when responding to a smallpox event.

Following a confirmed smallpox outbreak, rapid voluntary vaccination of a large populations may be required to: 1) supplement priority surveillance and containment control strategies in areas with smallpox cases, 2) reduce the “at-risk" population for additional intentional releases of smallpox virus if the probability of such occurrences is considered significant, or 3) address heightened public or political concerns regarding access to voluntary vaccination following a confirmed outbreak of smallpox. As the initiation of large-scale voluntary smallpox vaccination would be considered part of an overall national vaccination strategy, it would be initiated upon the recommendation of the Secretary of Health and Human Services to the President of the United States and with his concurrence.

In addition to the consideration outlined in *the general guidelines,* the following considerations apply when responding to a smallpox event:

1. Separate clinic(s) should be considered for vaccination and counseling of identified contacts to smallpox cases, but resources must also be available at voluntary clinics as some contacts may show up for vaccination at those facilities.
2. Medical screening for contraindications should be done and vaccination will not be recommended for persons with contraindications who are not otherwise identified as contacts.
3. Emergency treatment (i.e. allergic reaction, heart attack) will be treated at the mass clinic sites; however, treatment of adverse events will occur in separate medical facilities.
4. Pre-designated sites or clinics will be established, as part of the community smallpox response plan, for the evaluation of symptomatic individuals to rule-out smallpox. These evaluations sites will be separate from designated vaccination clinics, but should also have the capability to administer vaccination utilizing informed consent process (written scripts of the video may be, utilized if video viewing facilities aren't available).
5. The pre-designated sites for evaluating symptomatic individuals for smallpox will be identified in public service announcements and these individuals will be discouraged from presenting to voluntary vaccination clinics.
6. **Vaccine clinic and transportation personnel should be vaccinated prior to beginning vaccination clinic activities in order to provide protection against exposure from symptomatic contacts who may inadvertently present to the vaccination clinic. Establishment of voluntary clinics may need to be done in a stepwise fashion over 2-3 days to accommodate administration of staff vaccinations prior to opening a clinic. (NOTE: Vaccination clinic personnel do not require a "waiting period" before**

beginning vaccination activities. Personnel involved specifically in the triage and/or evaluation of ill individuals who present to the vaccination clinic can utilize other personal protective measures until a vaccine take is confirmed. Vaccination take rates are expected to be >95%.)

7. Pre-event targeted populations for smallpox vaccination are described on page _____.
8. NE HHSS will follow the ACIP (Advisory Committee on Immunization Practices) recommendations when administering smallpox vaccine, pre- and post event.

FEDERAL RESOURCES FOR SMALLPOX RESPONSE

The Federal Government will provide the following resources to state and local public health authorities for use in voluntary vaccination programs implemented following confirmation of a smallpox outbreak:

1. Smallpox vaccine and the following vaccine administration supplies: diluent for reconstitution of vaccine and bifurcated needles.
2. Vaccine administration directions (written and video demonstration)
3. IND Protocols and supporting materials in the major languages, including:
   a. Medical screening and consent form
   b. Information sheets on:
      - Smallpox Vaccine
      - Vaccine Adverse Events
      - Specialized information for persons with contraindications
      - Smallpox Disease
   c. Vaccine 'Take' Recognition Card
   d. Vaccine Site Care Instructions, and
   e. Vaccination Card for duplication and use within clinics
4. VIG available for use as an IND product for the treatment of serious adverse events, upon approved request.
5. Technical assistance with clinic design, development of clinic databases, and vaccination tracking systems.
6. *Assistance as otherwise outlined in the Federal Response Plan, if activated. [See Annex 2.]*

The amount of personnel resources provided by the Federal Government will be dependent upon the scale of the voluntary vaccination program. Additional government personnel resources available to the state and local authorities will be limited for any programs implemented on a large-scale in multiple sites (e.g., implementation of a nation-wide voluntary vaccination program).

VACCINE DELIVERY AND PACKAGING LOGISTICS

Once Federal authorities have authorized the release of vaccine, the initial vaccine shipment to a state or local area may be provided in a self-contained shipping and storage unit called a Vaxicool. One Vaxicool unit contains approximately 300 vials of vaccine and can also be used for continued storage of up to 300 vials of vaccine with an appropriate outlet power source. The number of vaccine vials contained within a Vaxicool unit may depend upon the specific vaccine dispensed (e.g.

Wyeth, Aventis, Acambis, or Baxter vaccine) and the potential need for refrigeration of the specific diluent during shipping.

Subsequent vaccine shipments will be in Styrofoam shipping containers. These Styrofoam shippers can support 100 to 1500 vials of vaccine depending upon the shipment size required. Vaccine shipped in Styrofoam containers will require arrangements for refrigerated storage at 2-8°C upon arrival. The need for storage of subsequent vaccine shipments of vaccine should be incorporated into all general smallpox vaccine storage site plans at the state level and all vaccination clinics planning logistics at the state and local level.

Diluent for vaccine reconstitution and needles for single use vaccine administration will also be included in all vaccine shipments, but may be in containers separate from vaccine. Shipments will contain vial holders to secure the vial and prevent accidental tipping during needle preparation for vaccination.

Current plans for rapid, large-scale shipment of vaccine through the National Pharmaceutical Stockpile (NPS) system allows for shipment of up to 500 Vaxicool systems on day 1 (75 million total vaccine doses), with up to 615 additional vaccine shipments/day in Styrofoam shipping containers from day 2-6. This plan provides for distribution of 280 million closes of smallpox vaccine from the SNS storage sites to states' field sites within 5-7 days. Vaccine shipments can also be dose adjusted and sent to cities with a population of 10,000 or greater.

Potential Types of Vaccine Formulations

Vaccine	Doses per Vial	Storage	Reconstitution/Storage
ACAM1 000 (Acambis)	100	2-8°C	0.25 ml of diluent. Store at 2-8°C once reconstituted
ACAM2000 (Baxter)	100	2-8°C	0.25 ml of diluent. Store at 2-8°C once reconstituted
Aventis Pasteur	100	0°C or below	0°C or below
Dryvax (Wyeth)	500	2-8°C	1.25 ml of diluent. Store at 2-8°C once reconstituted

NOTE: Since the brand of vaccine to be used will not be known beforehand, storage and handling instructions for the specific vaccine being used should be reviewed with ALL staff before they begin their shift.

LARGE SCALE VACCINATION CLINIC ORGANIZATION AND PERSONNEL ESTIMATES

The following section describes a model of a vaccination program that addresses the different activities needed for the administration of smallpox vaccine, as well as, an example of personnel estimates for staffing a smallpox vaccination clinic. The output goal of this example clinic model would be the administration of vaccine to 1 million persons over 10 days. The model can be contracted or expanded as needed to address vaccination administration goals for different population areas. The example staffing estimates were arrived at by: 1) review of previous large-scale clinic models and publications, 2) considerations of requirements for administering an IND vaccine, and 3) computer modeling for clinic flow and output estimates with different examples staff numbers. The computer modeling of the example clinic to determine staffing needs utilized the following parameters:

- 97% of people presenting to clinic will be processed through the normal clinic flow
  - 1 % will have some illness or condition that will require evaluation before processing through clinic
  - 2% will be identified as a contact or possible contact to smallpox and will be processed through the separate "Contact Evaluation" unit
- 20% of people coming through the clinic will require medical counseling in addition to the orientation video
  - Medical counseling/questions would require 5-15 minutes [some individuals will require > 15 minutes and others will require < 5 minutes]
  - Physician would be available to handle more difficult medical screening to keep clinic flowing
- 50% of persons getting additional medical counseling (i.e. the 20% above) will be vaccinated and 50% will defer vaccination because of contraindications or other reasons
- Distributing IND packets and providing initial instructions would take between 30 seconds - 2 minutes

- Video orientations are done approximately every 30 minutes in 5 orientation rooms that hold 75 people/room
- It will take 2-3 minutes for individuals to fill out the medical history screening forms
- Vaccination and completing vaccination cards would require between 0.5-2 minutes

The numbers shown in the table below are examples of the human resources needed with the above clinic assumptions and configuration.

Although staff numbers may vary depending on staff assignments and staff proficiency, the general tasks that must be addressed within a clinic (patient education, medical history screening, medical counseling, vaccination, etc.) will not change.

The example model assumes that clinics can be operating at near full efficiency to meet vaccination goals once the decision to offer voluntary vaccination is made.

Overall Vaccination Administration Goal = 1 million persons over 10 days
(Approximately 100,000 per day)

Clinic Estimates

Vaccination Clinics (VC)	**20 clinic sites**	More sites could be added to accommodate larger population bases
Vaccination Stations (VS)	8 VS per shift 1 vaccinator per station 0.5-1 witness/helper per station (who can also alternate vaccinating) 16 vaccinators/witnesses per shift	
Hours of Operation	At minimum 16 hours/day	Consider expanding hours for higher daily output or to address overflow.
Vaccination Delivery	• ~**30-60** vaccinations per VS/hour • ~**30-60** vaccinations/hr/VC • ~5900 per day/VC • ~118,000 per day total with 20 VC • 1 million vaccinated in ~ 9 days	30-60 vaccinations/VS/hour allows for variations due to vaccinator rotation, re-supply, completing vaccination card, etc.

Breakdown of Clinic Personnel per VC

Position	Number per 8th Shift	Number per 16th Day	Experience
Clinic Administrator	1	1	Medical or public health administrator
Forms distribution	9	18	Non-Medical volunteers
Triage for ill or contact	2	4	Nurse or EMT
Run Orientation video	8 (depends on room capacity)	16	Non-medical (5 running rooms and 3 floating between rooms to assist)
Referral personnel	7	14	Non-Medical volunteers
Medical screeners	7	14	Medical training required Nurse or MD
Physician Evaluators	2	4	Physicians to evaluate ill or more difficult medical history screening
Vaccinators/witness	16 (vaccinator witness, surge personnel)	32	Cross-trained to alternate vaccination, fill out vaccine card, sign as witness
Vaccine preparation/supply to VS	2	4	Pharmacist, pharmacy tech, or nurse experienced with vaccine or medication reconstitution
Exit Review	2	4	Medical or PH personnel for final questions/instructions
Medical Records/Data Entry	10	20	Non-Medical, data entry for information collected on vaccinees
Clinic Manager	2	4	Existing Vaccine Programs Personnel
Supply Manager	2	4	Non-Medical
Clinic Flow/QA reviewer/forms helpers	8	16	Non-Medical volunteers to assist with forms completion, collection, clinic flow
Security	30	60	Non-Public Health resource
Traffic Flow	2	4	Non-Medical, assist with loading and unloading buses at site if off site parking utilized
Translator (not counted in total clinic major language staffing estimates)	At least 1 per	Unknown	Language fluency with Training
Float Staff	3	6	Non-Medical volunteers
Contact Evaluation	4	8	Public Health
IT Support	1	2	Non-Medical
Total Personnel	117	234	

PERSONNEL RESPONSIBILITIES AND ESTIMATES OF PERSONNEL NEEDS, BASED ON THE MODEL

- **Clinic administrator** – 1 x 2 shifts = **2 total** – Overall responsibility for all clinic activities.
- **Forms/Info Packet Distribution** - 9 x 2 shifts; = **18 total** - Personnel to put together patient forms/information packets, hand out packets with information sheets/registration forms/informed consent/other IND forms (1 minute/person), clipboards, pencils, people to begin filling in demographic information on forms while in line awaiting initial clinic entry for video briefing.
- **Triage** [nurse or EMT]- 2 x 2 shifts = **4 total** - Triage personnel to direct ill patients to other evaluation facilities and direct identified contacts, persons with contact to a rash in last 3 weeks, and their household family members to high priority evaluation location within clinic (1 minute/person) Triage should also utilize signs explaining where people should go if they are ill, contacts, or neither if done at the clinic.[note: Ill persons should be triaged out and evaluated at designated off site parking sites before boarding bus for transportation to clinic if off site parking with busing is used for clinics].
- **Video Orientation** - 8 people x 2 shifts = **16 total** - Personnel to run video orientation regarding clinic procedures, paperwork, IND consent info, reasons for vaccination, contraindications to vaccination, **5 rooms running concurrently that hold 75 people/session with 2 staff/room** (~20minutes per session, allowing for 5-10 minutes for moving people into and out of orientation room) or a total of approximately **2 sessions/hour** (~750 people oriented/hr).
- **Referral Personnel** - 7 stations with 1 persons/station x 2 shifts = **14 total** [can be trained volunteers with no medical background]- to look at medical screening/vaccination consent forms and send persons without "yes" checked boxes who have signed form on to vaccination station and redirect people with contact checked boxes or other "yes" or 'maybe" checked boxes on to contact or medical screeners. Float staff personnel can relieve as needed to allow all 12 stations to continue running during staffing breaks.
- **Medical Screeners For Contraindications, Evaluation/informed Consent Questions Counseling** [should be medically trained personnel such as physicians, nurses, physician assistants, nurse practitioner, etc.) - 7 per shift x 2 shifts = **14 total** - Medical screeners to review patient history for those with contraindications and answer questions for informed consent (est. 5 -10 minutes/person), numbers may need to be increased if too many people need further screening and start to get backup at this part of clinic.
- **Physician Evaluators** - 2 x 2 shifts = **4 total** - Physicians to evaluate/examine triaged ill persons and provide backup counseling if needed to contacts and non-contacts identified with possible contraindications by medical screeners (-10 minutes/person), and evaluate any immediate problems following vaccination (fainting, anaphylaxis, etc.)
- **Vaccinators** about site care, adverse event symptoms or non-take reporting procedures/follow-up, etc. following vaccination.
- **Medical Records/Data Entry Personnel** - 10 x 2 shifts = **20 total** -collect retained records and enter registration/vaccination information (name, SS#, passport number/country, contact information, etc.) into database (estimated 1

minute/record entry if database already set up) - important to have on-site if possible to maintain "real-time" record of number of vaccinations and database for later use for AE's or non-takes requiring revaccination, web-based entry with centralized database of all clinics preferable.

- **Clinic Managers - 2 x 2 = 4 total** - Oversees all clinic **/Assistants** - 16x 2 shifts = **36 total** - 8 vaccination stations with 1.5-2 vaccinators per vaccination station/shift to trade off vaccination, fill out vaccination card, and witness/collect signed vaccination consent/med screening form (each of the 10 vaccinating stations doing 35-45 people/h for total of 360 people vaccinated/h) Vaccinators should consist of those allowed to administer vaccine under state law.
- **Vaccine Preparation For VS** - 2 x 2 shifts = **4 total** - For preparation of vaccine vials to supply VS as needed. Should be pharmacist, pharmacy tech, or other personnel trained in preparation of medications or reconstitution of vaccines and as allowed by state law.
- **Exit Review Personnel** - [should be medical or public health personnel] 2 x 2 shifts = **4 total** - personnel to answer any final questions functions/problem solving.
- **Supply Manager - 2 x 2 = 4 total - Oversees** all supply needs, tracks vaccine supply/lot numbers, distribution, and wastage, re-supplies vaccination stations.
- **Clinic Flow/QA/Forms Helper Personnel** [volunteers]- 8 x 2 = **16 total** - help maintain clinic flow, assist with forms, quality assurance, retrieve clipboards and forms from VS and takes forms to Med record entry personnel and clipboards back to form distribution, rotate through waiting areas to answer questions and talk with people to assure them as needed.
- **Security Personnel- 30 x 2 = 60 total** - maii1tain crowd control outside and security within clinic; assist with clinic and traffic control, etc. Non-public health resource, however arrangements must be made with appropriate agencies or organizations to provide security as part of coordinated planning.
- **Traffic Flow Personnel - 2 x 2 = 4 total** - maintain traffic flow and order in parking area if parking onsite, if busing in from off site parking, may not need.
- **Translators** - 1 for each major language spoken in community per shift, may need more depending upon major language of clinic population. Local and state authorities should identify language translations needed based on makeup of the community. Consider identifying specific clinics for referral of populations who need translators.
- **Float Staff Personnel [volunteers] - 3 x 2= 6 total** - float staff personnel to answer telephones, assist clinic personnel as needed.
- **Contact Evaluation Unit Personnel - 4 X 2 = 8 total** - for separate medical screening, education, and registering of identified contacts and their household contacts. Contacts will also be registered for surveillance for smallpox symptoms and given instructions on any travel restrictions and reporting requirements. Must be educated on contact surveillance process, smallpox signs/symptoms, etc.
- **IT Personnel** - 1 per shift x **2 = 2 total/clinic** - to support computer, programming, electronic equipment maintenance needs, etc.

Other Volunteers As Needed For Float Staff, Forms Assistance, Referral Personnel, etc.

- **VC Staff needed per single VC to cover two 8h shifts – approximately 234"(117 shift) + translators** [NOTE: 60 people are security people from non-public health resources]
- **Non-medical volunteers can be used for:** forms distribution, orientation video, referral personnel, data entry, supply manager, clinic flow/QA/forms assistance, security, traffic flow, translators, float staff and IT support.

Total Staff needed for 26 Vaccination Clinics –234/VC = 4680**
For 20 VC's operation 2 8h shifts/day + translators
[NOTE: ~26%, or 1,200 of these personnel are non-public health resources required for security.]

**Should consider increasing staffing by approximate 20% with cross-trained personnel to allow for no-shows, breaks, surge needs, etc.

CONSIDERATIONS FOR VACCINE NON-TAKES AND ADVERSE EVENTS

Telephone hotlines should be established for the following:

- **Reporting and Handling of Vaccination Non-Takes**

  Non-contacts: Vaccinated individuals who are not otherwise identified as contacts to a smallpox case will be given vaccination cards and vaccine take recognition cards at the time of their. vaccination (in the IND packet) and instructed to call a designated number (a hotline set up by local health officials) if their vaccination site does not resemble the picture on the card at day 7. They will be counseled through the hotline to return to a VC with their vaccination card for revaccination if they are suspected of having a vaccine non-take. Individuals presenting back to VC for re-vaccination would not require repeat medical screening as long as they present their vaccination card from the previous VC visit, but may be required to review the informed consent material (video) and sign an additional consent form. Following this, they can be triaged directly to the vaccination area for revaccination.

  Contacts: Vaccinated contacts under surveillance and their household members will also receive vaccine take recognition cards and vaccination cards. If possible, they will be followed up with visual confirmation of vaccine take as a part of the contact surveillance process. If visual confirmation is not possible due to a large number of contacts requiring surveillance by limited personnel resources, contacts and their household members will be instructed to report possible vaccine non-takes to a designated contact symptom surveillance telephone number at the local or state health department. Re-vaccination will be done for contacts and their household members who do not have a vaccine take at day 7. This may be done through referral back to the contact evaluation unit of a VC, referral to another specified location, or through direct administration of vaccine by health department personnel at the time of visual evaluation [dependent upon what is allowed through the IND process]

- **Reporting, Evaluation, and Treatment of Suspected Adverse Events**

Evaluation and treatment for vaccine adverse events should occur at a designated site or sites ' separate from VCs. A local telephone number for reporting of suspected adverse events should be established and staffed and included in the Smallpox Vaccine VIS that is handed out to vaccine recipients. Staff should be instructed on where to refer callers for further medical evaluation. As a part of smallpox BT planning, local and state health authorities should designate the facilities where suspected vaccine adverse events will be referred, evaluated, and treated. [See Annex 2]

Other Considerations

- *Consider ways to organize the population to attend a vaccination clinic on a day-by-day schedule; such as the use of the last 3 digits of the household head's Social Security number (e.g., Day 1: 000-099; Day 2: 100-199...Day 9: 900-999) or use of other neighborhood designations, worksite designation zip-codes, school districts, etc.*
- *Advise population to bring identification (e.g., Social Security card, drivers license, passport, or other ID)*
- *Advice population to wear short sleeve shirts to clinic.*

Logistics for Administration of Smallpox Vaccine

This section outlines the use of smallpox vaccine during the response to a smallpox emergency. This protocol will only be implemented as outlined below if there were to be a confirmed case of smallpox.

Please refer to sample Flow Diagrams:

- Public Service Announcements (PSA) are the first item for the logistics of the vaccination clinic. These PSA's are being crafted to include important information on the disease, vaccination, and contact numbers/vaccination clinics.
- Triage for Illness: The first triage point for the vaccination clinic is triage for illness and/or contacts of confirmed cases of smallpox. This checkpoint is to screen out those individuals that may be ill or contacts from the rest of the individuals at the clinic so as not to expose the clinic population.
    - Ill (e.g., fever or rash): These individuals will be taken out of the mainstream flow and will be attended to as required by their symptoms/illness (e.g., monitoring, vaccination, or supportive care). Contacts: These individuals will be taken out of the mainstream flow to be counseled and registered for monitoring for symptoms of smallpox.
    - Not Ill (mainstream progression through the clinic): Those individuals that will progress to the next station within the clinic who have not presented as ill or a contact.
- Distribution of Information Packet: All individuals (contacts and mainstream) will receive the "mainstream" information packet that will include all of the following information:
    - Video script
    - Screening form
    - Expanded Vaccine Information Statement (VIS)
    - Vaccination Site Care Card
    - Proof of Vaccination Card

After receiving this information "mainstream" individuals will proceed to the video screening area, while "contacts" will proceed to the contact evaluation area.

- Video Screening Areas: Individuals will view the video that contains the essential elements of informed consent as promulgated in 21 CFR 50.25. This video viewing will be witnessed to comply with FDA regulations for the oral presentation of consent information. The script of the video is included in the "mainstream" packet and will include language translations as necessary.

After the video, the individuals will be instructed to complete the screening form that will move them through the remainder of the vaccination clinic.

- Post Video Triage: Individuals will proceed to this triage point with their completed screening forms. The screening forms are for self-identified contraindications for the individual or family members with contraindications (e.g., contact history, altered immune status, autoimmune diseases, concomitant medications that alter immune status, skin conditions, pregnancy,

reactions to previous smallpox vaccinations, allergies to vaccine components, children less than 1 years old) and/or questions relating to the decision to be vaccinated.

- If the individual checks "yes" or "maybe" to any of the boxes on the Screening form- they will proceed to the Counseling Stations- where they will receive additional information based on the contra-indication that they checked.
- If the individual has no self-identified contraindications or questions they will proceed to the vaccination area.
- If the individual decides to decline vaccination, and is not a contact, they will be escorted to the exit.

- Vaccination Area:
  - At the vaccination station there will be the "Consent Roster" - individuals will sign that they have viewed the video and had all questions answered - they will also have the chance here to ask any remaining questions. If they have remaining questions, they may be referred back to the counseling area. At this point they will sign the roster for consent to be vaccinated.
  - If they refuse vaccination - they will sign a "Refusal Roster" that outlines that they have viewed the video and had questions answered and the are refusing vaccination at this time. If they are a contact to a case, then the patient should be instructed on appropriate quarantine measures, the symptoms to monitor for, and appropriate contact information.

Post Vaccination Information and Review: This is the final station in the clinic for any remaining questions. This station should also ensure that individuals exit with ALL their information sheets and instructions. (A supply of extra information sheets should be kept here to distribute, as needed.)

Form to calculate

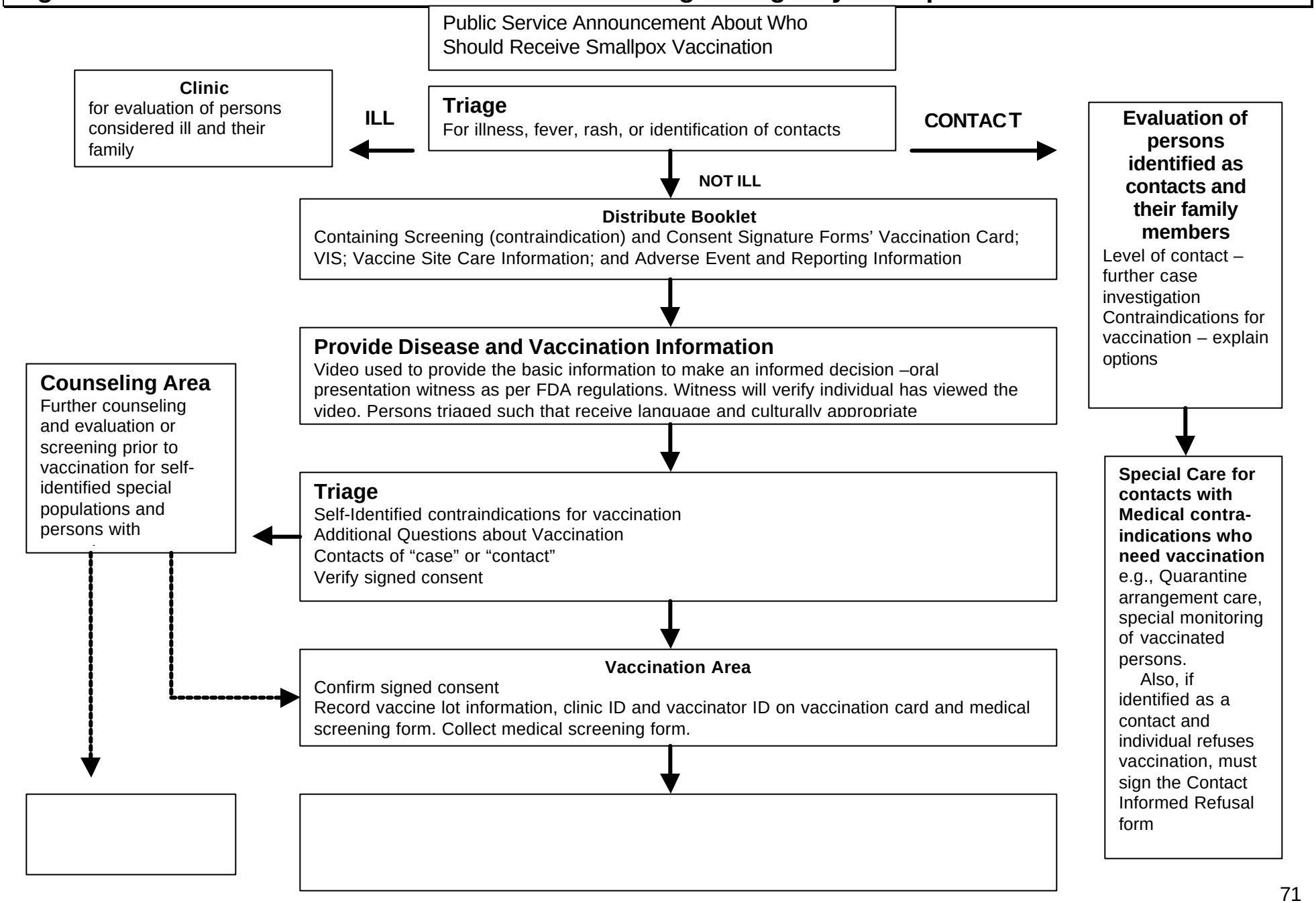
Breakdown of Clinic Personnel per VC

Position	Number per 8th Shift	Number per 16th Day	Experience
Clinic Administrator			Medical or public health administrator
Forms distribution			Non-Medical volunteers
Triage for ill or contact			Nurse or EMT
Run Orientation video			Non-medical (5 running rooms and 3 floating between rooms to assist)
Referral personnel			Non-Medical volunteers
Medical screeners			Medical training required Nurse or MD
Physician Evaluators			Physicians to evaluate ill or more difficult medical history screening
Vaccinators/witness			Cross-trained to alternate vaccination, fill out vaccine card, sign as witness
Vaccine preparation/supply to VS			Pharmacist, pharmacy tech, or nurse experienced with vaccine or medication reconstitution
Exit Review			Medical or PH personnel for final questions/instructions
Medical Records/Data Entry			Non-Medical, data entry for information collected on vaccinees
Clinic Manager			Existing Vaccine Programs Personnel
Supply Manager			Non-Medical
Clinic Flow/QA reviewer/forms helpers			Non-Medical volunteers to assist with forms completion, collection, clinic flow
Security			Non-Public Health resource
Traffic Flow			Non-Medical, assist with loading and unloading buses at site if off site parking utilized
Translator (not counted in total clinic major language staffing estimates)			Language fluency with Training
Float Staff			Non-Medical volunteers
Contact Evaluation			Public Health
IT Support			Non-Medical
Total Personnel			

Place Holder for General Population Vaccine Information Form

Place Holder for General Population
Vaccine Information Form

Fig 2. Informed Consent Process Flow for Use During Emergency Smallpox Vaccination



Attachment 2

Mass Patient Care Smallpox Response Planning Template for State and Local Jurisdictions

Planning parameters for managing the consequences of the release of smallpox, as a weapon of mass destruction will include a variety of factors at the local and state levels. All planning efforts must work in conjunction with established federal support planning. This template, along with the guidelines set forth by the CDC, will allow local jurisdictions and state agencies to effectively respond to a smallpox incident.

PLANNING CONSIDERATIONS FOR MASS PATIENT CARE

The primary consideration needs to be for the rapid expansion of capacity. This can be accomplished in a number of ways.

- **Expand existing personnel capacity by augmenting staff**

  Expansion of physical capacity can be accomplished by opening closed beds, wards, and floors. Converting large, interior spaces into patient care areas can develop further capacity.

  Looking first to some or all of the following local sources can augment staff: Medical Schools, Osteopathic Schools, Nursing Schools, Physician Assistant Programs, Dental Schools, Veterinary Medicine Schools, Vocational Nursing Programs, Physical Therapy Programs, Lab Technology Programs, EMT Training Programs, Dental Assistant/Hygienist Programs, Medical Records Programs, Nursing Assistant Programs, local chapters of the American Red Cross, Salvation Army, Fire Academies, and Police Academies. Consider adjacent/nearby military training reservations/academies.

  NOTE A: Each of these potential sources for augmenting staff may require the establishment of a Memorandum of Understanding. This must be done ahead of time. In addition to these local sources, the Department of Health and Human Services is initiating planning for the development of local Volunteer Medical Reserve Corps. (Information on building a local Volunteer Medical Reserve Corps will be provided by the Department of Health and Human Services.) Guidance for the development of a local Medical Reserve Corps will be made available in the near future.

  NOTE B: Each of these cohorts adds an additional vaccination requirement.

  An available source(s) of staff augmentation outside of local sources are Traveling Nurse companies. These companies advertise in the national nursing journals. Beyond that, it may be necessary to turn to assets that are available statewide and ultimately to the Federal Government for additional assets.

It is important to remember that augmentation needs for Mass Patient Care are *in addition to* those required for a Mass Vaccination Program. (It has been estimated that the personnel required to vaccinate a population of 1,000,000 persons over 7 days could be as many as 4,600 persons.)

- **Use of auxiliary facilities (e.g. hotels/schools)**
  An important consideration in planning for the use of auxiliary facilities is that those facilities may not ever be able to be used again as originally intended. The use of auxiliary facilities may require that some "standards of care" be relaxed. If so, it is important to address these legislative issues/concerns during the planning stage.
- **Move patients out (non-smallpox)**
- **Move Resources In (personnel, portable facilities)**
  Department of Defense mobile/portable facilities can be accessed through Emergency Support Number 8 of the Federal Response Plan.

  Home care may be suitable for the X and R patient cohorts described below. Plan for the three facility types recommended by the CDC in the referred to document. (C=Smallpox Patients; X=Vaccinated Febrile Patients without Rash; R=Asymptomatic Contacts)
  http://www.bt.cdc.gov/DocumentsApp/Smallpox/RPG/GuideC/guide-C-pages1-18only.pdf

COMMAND AND CONTROL

All elements of your command and control must be exercised regularly.

- Utilize the incident command system.
- Utilize the unified command system.
- Identify relevant contact information and update regularly.
- Notify necessary local, state, and federal agencies.
- Centralize Communications Control Center.
- Centralize Control of Medical Logistics and Equipment
- Centralize Control of Transportation.
- Consider use of non-traditional (alternate) means of emergency transportation, such as using public transportation for patient movement.
- Establish procedures for patient movement to appropriate facilities and mobility of healthcare providers to/from treatment facilities.
- Develop a family support center in coordination with the American Red Cross for the dissemination of information to family members of victims.

PERSONNEL REQUIREMENTS

Consider a vaccination plan for both personnel and their families.

Preparing for the consequences of a smallpox outbreak will require significant numbers of personnel associated with each component of the response. Resources provided by Federal and State agencies will not be sufficient to offset the medical human resource needs associated with a large-scale smallpox outbreak. Appropriate staffing of health and medical requirements will be critical for the success of this operation.

- Develop a plan for coordination with other local, state and federal agencies to avoid "double counting" potential augmentation resources.

- Address credentialing issues to allow non-local physicians and other care providers to legally practice within jurisdiction. Ensure that during a smallpox response, unlicensed personnel can be utilized under the supervision of licensed personnel.
- Manage the dissemination of information via Public Affairs.
- In-hospital providers and first responders who would respond to a smallpox case should be identified.
- Maintain adequate support staff (laundry, housekeeping, central supply) to provide mass care.
- Identify adequate hospital-based infectious disease specialists for disease consultation.
- Establish separate staffing to maintain normal medical functions, such as labor and delivery, non-related injuries.
- Provide for the segregation of providers treating smallpox victims from other providers.
- Establish control procedures to prevent medical personnel from fleeing from or flooding into medical treatment facilities.
- Consider the potential loss of healthcare providers due to smallpox exposure or fear of smallpox exposure.
- Consider auxiliary personnel to assist with mass care (e.g., medical/nursing/veterinary students).
- Establish vaccination plan for healthcare providers, public health officials, and their families.
- Identify personnel mobilization points.
- Provide for the welfare and safety of emergency workers. It is important to remember that auxiliary response personnel may number in excess of 5,000 persons.
- Provide appropriate personal protective equipment and infection control measures for personnel.
- Include numbers of personnel required by category (physician, nurse, EMT).
- Consider the use of non-traditional personnel as described on Page 1.
- Use auxiliary personnel (who may be trained on the spot but will require close professional supervision).
- Train support personnel (e.g., clergy, mental health workers) in the use of personal protective equipment and infection control procedures.
- Develop family support plan for medical providers and response personnel.
- Develop plan for the housing, feeding, and clothing needs of emergency responders.

TREATMENT

- Train medical staff to recognize and manage smallpox patients, special considerations include immune compromised patients and patients with adverse vaccination reactions.
- Provider appropriate personal protection equipment.
- Provide treatment protocols to all providers that include plans for immunocompromised patients.
- Prepare to maintain appropriate documentation.
- Develop triaging procedures for smallpox victims.

- Establish a hotline number for information on vaccination takes.
- Develop information for those whose vaccinations do not take, including information about revaccination.
- Must be prepared to treat persons with adverse reactions to vaccination. These patients must not return to the mass vaccination site.
- Utilize telemedicine for consultation.

PROVISION OF MENTAL HEALTH SERVICES

- Plan for mental health services for victims and their families.
- Plan for mental health services for emergency workers and their families.
- Plan for the management of the worried well and provision for psychological counseling of the same.

PATIENT TRACKING

- Match patients with appropriate medical facilities and other pre-selected treatment locations.
- Track patients at all facilities.

FACILITIES

- Plan for the three facility types recommended by the CDC in the referred to document. (C=Smallpox Patients; X=Vaccinated Febrile Patients without Rash; R=Asymptomatic Contacts)

http://www.bt.cdc.gov/DocumentsApp/Smallpox/RPG/GuideC/guide-C-pages1-18only.pdf

- Home care may be suitable for the cohorts X and R noted above.
- Plan for admission procedures for smallpox patients into hospitals or established treatment facility.
- Establish a standardized community reporting method to report bed availability.
- Establish plans for the expedient expansion of the existing healthcare system capacity.
- Utilize isolation beds within existing facilities.
- Maximize utilization of existing healthcare facilities, including augmentation of staff.
- Consider secondary treatment centers for temporary augmentation of healthcare capabilities.
- Consider the use of long-term care facilities.
- Consider the use of warehouses/schools, keeping in mind that such use may render the facilities permanently contaminated and/or may require extensive decontamination.
- Consider the use of neighborhood-based treatment centers versus centralized treatment centers.
- Consider the integration of Federal assets, such as Veteran Administration (VA) and Department of Defense (DoD) medical treatment facilities and NDMS/DoD field hospitals into existing local plans.
- Establish procedures to staff, equip and transport personnel and victims to/from secondary treatment facility.
- Establish procedures for the movement of patients not infected with smallpox to other locales (e.g., NDMS).

- Ensure adequate monitoring of the food, air and water within medical treatment facilities.
- Enforce strict infection control procedures.
- Review and utilize CDC's Decontamination Guidelines. (Guide F: Pages 1-6)
  http://www.bt.cdc.gov/Agent/Smallpox/Smallpox.asp

ISOLATION OF PATIENTS

- Identify personnel responsible for local/state coordination of activities.
- Identify appropriate facilities to be utilized for isolation and care.
- Identify appropriate law enforcement entities to enforce isolation and to control access to facilities.
- Review and coordinate plan with CDC Isolation Guidelines.
- CDC Isolation and Quarantine Guidelines (Guide C: Pages 1-23)
  http://www.bt.cdc.gov/Agent/Smallpox/Smallpox.asp

SECURITY

- Provide security for medical treatment facilities and medical personnel (e.g., crowd control, preventing a rush of individuals wanting treatment and vaccinations).
- Provide security for medical supplies.

NOTE C: This may create a new cohort requiring vaccination.

TRAINING AND EXERCISES

- Train personnel regarding the clinical aspects of a smallpox response.
- Train healthcare and civilian personnel regarding the principles of homecare.
- Train personnel on proper isolation techniques.
- Exercise mechanisms to adapt and expand existing facilities.
- Exercise all components of the local response system.

PLANNING CONSIDERATIONS FOR MASS FATALITY MANAGEMENT

- Plan for vaccinating mortuary personnel and their families.
- Maximize use of existing facilities.
- Establish plans for the use of non-traditional facilities to augment existing facilities (e.g., cold storage, reefers).
- Establish plans requesting deployment of NDMS/DoD assets (portable morgue facilities and personnel to augment local capability).
- Establish plans to identify the deceased.
- Establish plans to augment with NDMS/DoD assets, as necessary.
- Establish decontamination/isolation procedures available to terminal care providers.
- Establish containment procedures for the deceased, following established protocols for double-body bagging/double taping.
- Exclude embalming procedures.
- Consider use of vaults for burial purposes, if they are available and can handle more than one body. Above ground mausoleums will not be used.
- Establish plans for engaging the religious community.
- Prepare for appropriate documentation.

Attachment 3

Clinic Preparation Checklists

Smallpox Post-Event Clinic Preparation Checklist

Overall Planning and Management

- ❑ Metro-Central Headquarters Identified
  - ❑ Location
  - ❑ Staffing for General Operations
  - ❑ Staffing for Problem-Solving
  - ❑ Memoranda of Understanding (as required)
  - ❑ Communications Protocol

- ❑ Central Vaccine Storage Site Identification
  - ❑ Central facility with security and backup generator
  - ❑ Central Supplies Warehouse
  - ❑ Shipping Company Selection
  - ❑ Printing Company Selection (for mass form production)

- ❑ All Supply Resources Identified (See Supply and Equipment Checklist)

- ❑ Vaccination Clinic Site Identification (x20)

- ❑ Procedure for Designating Vaccination Site/Time (i.e., zip code? SSN?)

- ❑ Procedure for Identification

- ❑ Computer Networking Identified for Exchange of Data

- ❑ Standing Orders for Emergencies

- ❑ Agreement(s) with local media for public service announcement coverage/production

Smallpox Post-Event Clinic Preparation Checklist

Clinic Site Checklist

Clinic Site: Number of

- ☐ Facility Resources
  - ☐ Large, open space to accommodate clinic flow
  - ☐ Weather Protection for those in line
  - ☐ Ability to be made secure
  - ☐ Backup generator
  - ☐ Accessible for People with Disabilities
  - ☐ Ease of Access for Community
  - ☐ Communication Resources Available
  - ☐ Equipment Resources Available (See Supply and Equipment Checklist)
  - ☐ Tables Available
  - ☐ Screening Rooms Available
  - ☐ Waste Disposal
  - ☐ Rest Area for Staff
  - ☐ Transportation/Parking for Staff?

- ☐ Transportation Procedures
  - ☐ Parking Identified
  - ☐ Bus Service Company Selection
  - ☐ Routes for Bus Service

- ☐ Vaccination Clinic Personnel Identified (See Personnel Checklist)
  - ☐ Vaccinators
  - ☐ Physician Evaluators
  - ☐ Support Functions

- ☐ HIV Testing Referral Plan

- ☐ Equipment Resources Identified (See Supply and Equipment Checklist)

Smallpox Post-Event Clinic Preparation Checklist

Supply and Equipment Checklist

Clinic Site: Number of

Equipment Needs

- ☐ Copier
- ☐ FAX Machine
- ☐ 12 Computers or Laptops
- ☐ 5 DVD or VCR Players
- ☐ 5 Large-Screen Televisions
- ☐ Cell Phones
- ☐ Handheld Radios

General Supplies

- ☐ Tables
- ☐ Chairs
- ☐ Water and Cups
- ☐ Paper
- ☐ Pens, Pencils
- ☐ Envelopes
- ☐ Rubber Band
- ☐ Tape
- ☐ Paper Clips
- ☐ Scissors
- ☐ Post-It-Notes
- ☐ File Boxes
- ☐ Telephone
- ☐ Paper Towel
- ☐ Tissues
- ☐ Table pads and clean paper
- ☐ Garbage containers
- ☐ Trash Bags
- ☐ ID Badges for Staff
- ☐ 7 Copies of Video
- ☐ Food and Drink for Staff
- ☐ List of Emergency Phone #s
- ☐ Cleaning Supplies
- ☐ Stapler/Staples

Crowd Management and Triage Supplies

- ☐ Queue Partitions
- ☐ Signs for Site Designation
- ☐ Signs for Clinic Flow

Vaccine Administration Supplies

- ☐ Smallpox Vaxicools/Refrigerator
- ☐ Vaccine Diluent
- ☐ Sterilized Bifurcated Needles
- ☐ Sharps Containers
- ☐ Laxtex Gloves
- ☐ Laxtex-Free Gloves
- ☐ Anti-Bacterial hand washing solutions
- ☐ Acetone
- ☐ Rectangle Band-Aids
- ☐ Gauze
- ☐ Adhensive Tape
- ☐ Spray Bottle of Bleach Solution
- ☐ Paper Gowns
- ☐ Vaccination Screens

Emergency Supplies

- ☐ Standing Orders for Emergencies
- ☐ "Code" kit with defibrillator
- ☐ Ampules of Epinephrine 1:1000 SQ, or
- ☐ EPI Pen Adult/EPI Pen Child
- ☐ Ampules of diphenhydramine (50mg IM)
- ☐ 3cc syringes with 1", 25-guage needles
- ☐ 1.5" needles
- ☐ Tuberculin syringes with 5/8" needles
- ☐ Alcohol Wipes
- ☐ Blood Pressure Cuffs (various sizes)
- ☐ Oxygen Tank
- ☐ Oxygen Tank Tubing
- ☐ IV Solution
- ☐ IV Solution Tubing
- ☐ Thermometer
- ☐ Aspirin, Tylenol, Regular insulin, D50
- ☐ Asthma Inhaler
- ☐ Tongue Depressors
- ☐ Emesis basis
- ☐ Adult pocket masks with one-way valve
- ☐ Pediatric pocket masks with one-way valve
- ☐ Adult and pediatric airways
- ☐ Tourniquet
- ☐ Gurney
- ☐ Stethoscope
- ☐ Flashlight
- ☐ Cots, Blankets, and Pillows
- ☐ ER Report Form

DETERMINING CLINIC CAPACITY

45 PEOPLE PER HOUR x 6 LINES = 270 PEOPLE PER HOUR

270 PEOPLE PER HOUR x 8 HOURS – 2,160 PEOPLE PER 8 HOUR SHIFT

2,160 PEOPLE PER 8 HOUR SHIFT x 2 SHIFTS = 4,320 PEOPLE PER DAY (2 shifts)

DETERMINING HOW MANY CLINICS ARE NEEDED TO VACCINATE YOUR POPULATION IN 4 DAYS

50,000 POPULATION / 4,320 PER DAY = 12 DAYS (11.57) TO VACCINATE WITH ONE CLINIC SITE

12 DAYS / 4 DAYS = 3 SITES MINIMUM NEEDED TO VACCINATE IN 4 DAYS

Form to calculate

Breakdown of Clinic Personnel per VC

Position	Number per 8 h Shift	Number per 16th Day	Experience
Forms distribution			Non- Medical volunteers
Triage for ill or contact			Nurse or EMT
Run Orientation video			Non-medical (5 running rooms and 3 floating between rooms to assist)
Referral personnel			Non-Medical volunteers
Medical Screeners			Medical training required Nurse or MD
Physician Evaluators			Physicians to evaluate ill or more difficult medical history screening
Vaccinators/witness			Cross-trained to alternate vaccination, fill out vaccine card, sign as witness
Vaccine preparation/supply to VS			Pharmacist, pharmacy tech, or nurse experienced with vaccine or medication reconstitution
Exit Review			Medical or PH personnel for final questions/instructions
Medical Records/Data Entry			Non-Medical, data entry for information collected on vaccinees
Clinic Manager			Existing Vaccine Programs Personnel
Supply Manager			Non-Medical
Clinic Flow/QA reviewer/forms helpers			Non-Medical volunteers to assist with forms completion, collection, clinic flow
Security			Non-Public Health resource
Traffic Flow			Non-Medical, assist with loading and unloading buses at site if off site parking utilized
Translator (not counted in total clinic staffing estimates)	At least 1 per major language per shift		Language fluency with Training
Float Staff			Non-Medical volunteers
Contact Evaluation			Public Health
IT Support			Non-Medical
Total Personnel			

Smallpox Post-Event Clinic Preparation Checklist

Personnel Checklist

Clinic Site: Number of

☐ **Forms Distribution**

AM Shift

1. 6.
2. 7.
3. 8.
4. 9.
5.

PM Shift

1. 6.
2. 7.
3. 8.
4. 9.
5.

☐ **Triage for Ill or Contacts**

AM Shift

1. 2.

PM Shift

1. 2.

☐ **Run Orientation Video**

AM Shift

1. 5.
2. 6.
3. 7.
4. 8.

PM Shift

1. 5.
2. 6.
3. 7.
4. 8.

☐ **Referral Personnel**

AM Shift

1. 9..
2. 10.
3. 11.
4. 12.
5. 13.
6. 14.
7. 15.
8. 16.

PM Shift

1. 9..
2. 10.
3. 11.
4. 12.
5. 13.
6. 14.
7. 15.
8. 16.

☐ **Medical Screeners**

AM Shift

1. 5.
2. 6.
3. 7.
4.

PM Shift

1. 5.
2. 6.
3. 7.
4.

☐ **Physician Evaluators**

AM Shift

1. 2.

PM Shift

1. 2.

☐ **Vaccinators**

AM Shift

1. 9..
2. 10.
3. 11.
4. 12.
5. 13.
6. 14.
7. 15.
8. 16.

PM Shift

1. 9..
2. 10.
3. 11.
4. 12.
5. 13.
6. 14.
7. 15.
8. 16.

☐ **Vaccine Preparation/Supply**

AM Shift

1. 2.

PM Shift

1. 2.

☐ **Vaccine Preparation/Supply**

AM Shift

1. 2.

PM Shift

1. 2.

☐ **Exit Review**

AM Shift

1. 2.

PM Shift

1. 2.

☐ **Medical Records/Data Entry**

AM Shift

1. 6.
2. 7.
3. 8.
4. 9.
5.

PM Shift

1. 6.
2. 7.
3. 8.
4. 9.
5.

☐ **Clinic Manager**

AM Shift

1. 2.

PM Shift

1. 2.

☐ **Supply Manager**

AM Shift

1. 2.

PM Shift

1. 2.

☐ **Clinic Flow/QA Reviewer/Forms Helpers**

AM Shift

1. 5.
2. 6.
3. 7.
4.

PM Shift

1. 5.
2. 6.
3. 7.
4.

☐ **Security**

AM Shift

1. 16.
2. 17.
3. 18.
4. 19.
5. 20.
6. 21.
7. 22.
8. 23.
9. 24.
10. 25.
11. 26.
12. 27.
13. 28.
14. 29.
15. 30.

PM Shift

1. 16.
2. 17.
3. 18.
4. 19.
5. 20.
6. 21.
7. 22.
8. 23.
9. 24.
10. 25.
11. 26.
12. 27.
13. 28.
14. 29.
15. 30.

☐ **Traffic Flow**

AM Shift

1. 2.

PM Shift

1. 2.

☐ **Translators**

AM Shift

1. Language:
2. Language:

PM Shift

1. Language:
2. Language:

☐ **Float Staff**

AM Shift

1. 3.
2.

PM Shift

1. 3.
2.

☐ **Contact Evaluation**

AM Shift

1. 3.
2. 4.

PM Shift

1. 3.
2. 4.

☐ **IT Support**

AM Shift

1.

PM Shift

1.

PRE-EVENT PLANNING - RESPONDING TO THE POTENTIAL FOR A SMALLPOX EVENT IN NEBRASKA

Why is there concern about smallpox?
Smallpox vaccination was discontinued when the World Health Assembly officially certified the global eradication of smallpox in May 1980. The only remaining stocks of smallpox viruses were secured for research purposes in the United States and the Soviet Union. There is concern that the Soviet Union's "research" included the possible reintroduction of smallpox virus back into the world's population for use as a biological weapon.

What is being done to prepare for the possible use of smallpox as a bioterrorism weapon?

As part of the response planning taking place, the Office of Homeland Security and the Nebraska Health and Human Services System (HHSS), with the assistance of an advisory committee, have developed a plan for limited pre-event vaccination. Since no guidance has yet to be received from the Centers for Disease Control and Prevention (CDC) regarding this issue, the committee prioritized pre-event vaccination, anticipating that Nebraska will receive vaccine in increments of 500 doses per vial. A Public Health Strike Force has been included in the use of the first 500 doses. The pre-event vaccination plan provides limited protection in the unlikely event that the initial case(s) would occur in Nebraska. In the actual event of proven smallpox, a definite, intentional bioterroristic act of war, the CDC will provide further guidance concerning targeted recipients and possible mass vaccination.

Who is targeted to get the vaccine?
In the '500 dose' plan, the vaccine will be distributed among health care providers across the state who might first encounter the potential smallpox cases. Additionally, it is planned that vaccinated hospital providers will provide relief to a hospital contaminated, or thought to be contaminated with a smallpox victim, protecting the health care workers not vaccinated pre-event. Vaccine will also be offered to pre-designated individuals who will transport patients to receiving hospitals with additional vaccine going to pre-identified individuals within the hospitals themselves. The remainder of the vaccine will be administered to the Public Health Strike Team who will investigate the potential cases, coordinate the outbreak response, begin the criminal investigation, contact the CDC for assistance, order in additional vaccine supplies, and assist communities with the immunization of both exposed individuals and others.

How many doses are the hospitals receiving? Who else will get vaccinated?
First and foremost, vaccination is voluntary. In the '500' dose plan, each of the hospitals likely to receive referrals, in the state's nine (9) largest counties (Adams, Buffalo, Douglas, Hall, Lancaster, Lincoln, Madison, Sarpy, and Scotts Bluff), will receive six (6) doses of vaccine. The hospitals in the remaining smaller

counties will receive three (3) doses per hospital. Indian Health Service sites in Winnebago, Macy and Santee will receive two (2) doses each.

The remaining doses will be administered to the Nebraska Smallpox Public Health Strike Force. Strike Force members will investigate potential cases, coordinate the outbreak response, begin the criminal investigation, contact the CDC for assistance, order in additional vaccine supplies, and assist communities with the immunization of exposed individuals and others. The Strike Force includes public health officials and staff, air ambulance services, Nebraska State Patrol, translators and others with high potential for face to face contact.

Who, in the hospitals, should get those doses?
Each hospital will decide who is on its smallpox response team. The team should be made up of those most likely to respond to a suspected or confirmed case and should include a physician, physician assistant or advanced practice registered nurse. Other team members might include nursing, laboratory or radiological staff so that a variety of health professions are available to provide relief to a hospital with a suspected or proven case of smallpox. Please submit the name of your hospital, and response team members, by name and profession, by October 25, 2002 to:

Christine M. Newlon, R.N., Administrator
Communicable Diseases
NE Health & Human Services Regulation & Licensure
PO Box 95007-5007
Lincoln, NE 68509-5007
402-471-2937
FAX: 402-471-3601
E-Mail: christine.newlon@hhss.state.ne.us

What are the contraindications? Who should <u>not</u> volunteer to be vaccinated?
When there has been no exposure, the following are considered to be contraindications:

- Weakened immune system (i.e. HIV/AIDS; cancer);
- Pregnancy;
- Receiving oral steroids;
- History of eczema or atopic dermatitis;
- Other skin conditions such as burns, impetigo, contact dermatitis, or zoster;
- Allergies to antibiotics polymixin, streptomycin, chlortetracycline, or neomycin

In addition to the contraindications previously listed, persons should <u>not</u> volunteer for pre-event vaccination if they:

- Regularly provide care to immunocompromised patients;
- Live with someone who is:
  - Immunocompromised;

- Pregnant;
- Under one year of age.

What are the risks of vaccination and can the reactions be treated?
Some sources estimate that 30% of vaccinees will miss at least one day of work because of reactions to the vaccine. Initial studies have shown that those previously vaccinated are less likely to react to the vaccine.

- Mild to moderate reactions:
  - Swelling and tenderness of lymph nodes, lasting 2-4 weeks after the blister has healed
  - Fever of over 100º F occurs in about 70% of children, but is less common in adults.
  - Secondary blister elsewhere on the body (about 5 per 10,000)
  - Mild rash, lasting 2-4 days

- Moderate to severe reactions:
  - Vaccine rash on entire body (about 2-3 per 100,000)
  - Severe rash on people with eczema (about 4 per 100,000)
  - Encephalitis (severe brain reaction), which can lead to permanent brain damage (about 1 per 100,000)
  - Severe infection beginning at the vaccination site (about 1-2 per million)
  - Death (about 1 per million, mostly in people with damaged immune systems)

Treatment for reactions:

There are two treatments for serious reactions to smallpox vaccine. They are Vaccine Immune Globulin (VIG) and Cidofovir. Both medications are given intravenously. These treatments are investigational and may also cause serious side effects.

When will the hospitals receive the vaccine?
While it is anticipated that the vaccine may be distributed in the near future, the date has not yet been announced. It is Nebraska's intent to have individuals identified prior to the release of the vaccine so that response teams can be vaccinated as soon as possible.

Who will administer the vaccines to the response teams?
If Nebraska receives 500 doses of vaccine in one multi-dose vial, it is anticipated that regional vaccination sites will be set up and the vaccine will be administered by NE HHSS staff. If Nebraska receives more than 500 doses of vaccine for pre-event, the plan identifies who the additional pre-event vaccine recipients will be. Vaccination plans may change, depending on the amount of vaccine Nebraska receives.

Will this plan change?

It must again be stressed that it is unknown if Nebraska or any other state will receive vaccine under the scenarios Nebraska used in drafting its plan. If the state does receive vaccine pre-event, it is not known how doses will arrive or if the CDC will have limitations on who may be vaccinated.

What is known is that the CDC has Nebraska's current pre-event plan and is reviewing it as a unique plan that takes rural hospitals into consideration for preparation for a suspected or proven first case of smallpox, in light of the state's limited health care resources, and also recognizes the need for accurate translation services in the lesser populated counties. Nebraska's plan has also been made available through the association of State and Territorial Health Officers to other states with similar demographics.

Where can additional information about smallpox, bioterrorism and response, be found?
The following websites are excellent resources for practitioners and the general public regarding Bioterrorism and Response:

NE HHSS: www.hhs.state.ne.us
CDC: www.cdc.gov

Any questions can be directed to Chris Newlon:

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NE Health & Human Services Regulation & Licensure
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402-471-2937
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Nebraska – Smallpox Public Health Strike Force

	Doses Needed
Deputy Chief Medical Officer	1
State Epidemiologist	1
Immunization Program/Disease ControlInvestigative Staff (1 Scottsbluff, 1 North Platte, 1 Kearney, 1 Verdigree, 6 Lincoln, 1 Omaha)	11
Disease Control –Program Manager	1
Immunization – Program Manger	1
Arturo Coto (HHSS Public Health Assurance, *DXed Smallpox and Bilingual)	1
Large Health Departments located in Douglas and Lancaster Counties (15 doses each, identification of vaccine recipients determined at the local level)	30
Air Mobile Ambulance Services (30 doses) Confirm that if unable to fly vaccine recipients can travel on ground transportation otherwise prioritize to ground ambulance to assure coverage in all weather	30
Nebraska State Patrol (6 doses)	6
Public Health Lab	4
Others with potential face to face contact (i.e., Infectious Disease Specialists, Dermatologists, etc.)	60
Translators	24
TOTAL	170

Smallpox Scenario #2	**500** **Doses**
Number of Vaccine Doses Allocated	**Target Groups**
170	Public Health Strike Team
96	Hospitals located in large Counties likely to receive referrals [Douglas (6), Sarpy (1), Lancaster (3), Hall (1), Buffalo (1), Adams (1), Lincoln (1), Scotts Bluff (1), Madison (1)] #6 doses per hospital
222	Health Care Providers located in 72 small counties (3 doses per hospital) and 6 doses for Indian Health Services (Winnebago, Macy, Santee)
488	

Smallpox Scenario #3	**1000** **Doses**
Number of Vaccine Doses Allocated	**Target Groups**
170	Public Health Strike Team
96	Hospitals located in large Counties likely to receive referrals [Douglas (6), Sarpy (1), Lancaster (3), Hall (1), Buffalo (1), Adams (1), Lincoln (1), Scotts Bluff (1), Madison (1)] #6 doses per hospital
222	Health Care Providers located in 72 small counties (3 doses per hospital) and 6 doses for Indian Health Services (Winnebago, Macy, Santee)
250	Medical Specialists to be allocated to hospitals per census
	Essential Services
	Potential Targets
	Local and Regional Health Departments
45	FBI & other Law Enforcement including tribal law enforcement
200	National Guard Security
983	

Smallpox Scenario #4	**1500** **Doses**
Number of Vaccine Doses Allocated	**Target Groups**
170	Public Health Strike Team
96	Hospitals located in large Counties likely to receive referrals [Douglas (6), Sarpy (1), Lancaster (3), Hall (1), Buffalo (1), Adams (1), Lincoln (1), Scotts Bluff (1), Madison (1)] #6 doses per hospital
222	Health Care Providers located in 72 small counties (3 doses per hospital) and 6 doses for Indian Health Services (Winnebago, Macy, Santee)
250	Medical Specialists to be allocated to hospitals per census
150	Essential Services
	Potential Targets
50	Local and Regional Health Departments
45	FBI & other Law Enforcement including tribal law enforcement
200	National Guard Security
300	Immunization Providers
1483	

Date: November 13, 2002

TO: Nebraska School Officials

FROM: Doug D. Christensen, Commissioner of Education
Richard A. Raymond, MD, HHSS Chief Medical Officer
Joann Schaefer, MD, HHSS Deputy Chief Medical Officer

RE: Bioterrorism Planning for Mass Public Clinics

During the last few weeks, Nebraska has received a significant amount of press coverage and national recognition regarding its ongoing bioterrorism response planning. The Nebraska Office of Homeland Security and state agencies are working diligently to prepare and refine a contingency plan for responding to different events that could trigger a public health emergency. The Nebraska Health and Human Services System just completed meetings across the state with local health departments, emergency response and law enforcement personnel, and other community leaders. The subject of the meetings was smallpox preparedness.

Smallpox disease was declared to be eradicated from the world in May, 1980; however, there is now concern that the virus may be reintroduced into the population as a biological weapon. The Federal Government has instructed all states to develop operational plans for responding to a case of smallpox disease. Part of Nebraska's plan will include protocol and directions for vaccinating the state's entire population in four days.

Your local public health officials will likely be calling you in the next few weeks to discuss using school facilities as emergency clinic sites, and asking for volunteer personnel, in the event of a public health emergency. Nebraska's success in responding to any catastrophe has always relied on collaboration between public and private partners at the state and local levels. We strongly encourage you to participate in the planning process and offer your support and assistance as needed for benefit of your community.